Maternal and Child Health Services
Title V Block Grant

State Narrative for Rhode Island

Application for 2011
Annual Report for 2009

Document Generation Date: Saturday, September 18, 2010

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I. General Requirements

A. Letter of Transmittal

The Letter of Transmittal is to be provided as an attachment to this section.
An attachment is included in this section.

B. Face Sheet

The Face Sheet (Form SF424) is submitted when it is submitted electronically in HRSA EHB. No hard copy is sent.

C. Assurances and Certifications

The following assurances and certifications are maintained on file in the Division of Community, Family Health and Equity at the Rhode Island Department of Health:

Non-construction program
Debarment and suspension
Drug free work place
Lobbying
Program fraud
Tobacco smoke

Assurances and certifications can be obtained by contacting:

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D. Table of Contents

This report follows the outline of the Table of Contents provided in the "GUIDANCE AND FORMS FOR THE TITLE V APPLICATION/ANNUAL REPORT," OMB NO: 0915-0172; published March 2009; expires March 31, 2012.

E. Public Input

Community participation in the needs assessment process is an important aspect to understanding the Maternal and Child Health needs in Rhode Island. In order to better understand the needs of the community, a combination of quantitative and qualitative examination is required. The three components of the community participation in the five-year needs assessment process were: a community input meeting, ten community forums and a public hearing. Information related to state needs, capacity and priorities was collected at these meetings that included various internal and external stakeholders, other state agencies, providers, and consumers, including parents of children with special health care needs.

Community Input Meeting
The Community Input Meeting was held in partnership with RI KIDS COUNT and the RI Department of Health with over 130 participants representing a diverse mix of over 40 community

organizations. A presentation on "building equity" by the executive director of the Division of Community, Family Health & Equity (CFHE) provided the framework for the discussions. Participants were invited to participate in breakout sessions based on the priority population groups identified: Early Childhood, Middle Childhood, and Adolescence, Children and Youth with Special Health Care Needs (CYSHCN), Pregnant Women and Women across the Lifespan. For each priority population breakout session, a population-specific data brief was provided to the participants and summarized at the beginning of the session. Copies of the briefs are included in the needs assessment appendix.

Community Forums

Nine community forums took place throughout the state at a range of settings including a women's health council, women's health advisory council, and children's advocacy organizations, with a total of over 200 participants. The community forums identified many of the same themes that the community input meeting did, including issues around access to care, gaps in mental health care, and social determinants of health.

The issues related to children are sometimes specific to a particular developmental stage, and sometimes overlap across the age span. Around the issues related to Early Childhood, the community forums identified the need for child development and referral networks for participants in Early Intervention. For Middle Childhood population, the issue of a lack of mental health services was again stated as a top priority - including psychiatry, psychology, school-based and group services. The groups emphasized the importance of using KIDSNET share information and data. They stated the need to ensure screening, immunization, dental care and healthcare coverage for children of all ages. For Adolescence, the importance of working with schools to: increase physical activity, comprehensive sex education, Vaccinate before You Graduate, and behavioral health services was emphasized. The groups stated the importance of addressing special at risk populations of adolescents, including the homeless, LGBT, and pregnant or parenting teens who are at high risk for adverse outcomes. The importance of addressing the childhood obesity epidemic was listed as an area of concern across all groups and every setting.

For CYSHCN, the community groups prioritized activities to increase social engagement for CYSHCN such as opportunities for recreation, sports, after-school activities, and peer-to-peer mentoring programs. The groups stated the need for increased support for and expansion of the Pediatric Practice Enhancement Project (PPEP). The community input groups cited the need to decrease barriers to services such as transportation, and to expedient access to durable medical equipment. They stressed the need to increase awareness of services available, especially in minority communities. The community stated the importance of risk reduction strategies with CYSHCN who are at higher risk for mental health issues, substance use disorders, and obesity. Finally, the need to try to improve access to prenatal care and early screening services to maximize the potential of each individual child was emphasized.

For Pregnant Women, the groups emphasized the importance of increasing participation in pre-conception, pre-natal, parenting classes, tobacco cessation and breastfeeding education programs. The groups suggested offering incentives that might increase participation such as diapers, food, etc. They emphasized the need to reduce barriers to access to prenatal care and proposed that group visits such as the "centering model" may be one way to increase access. Reimbursement schemes must be simplified and presented clearly to consumers and providers. Finally, the importance of screening and linking women to services for post-partum depression was again cited as a top priority for pregnant women in RI. The forums that contributed to Women across the Life Course, emphasized the importance of working with health insurers and the provider community to increase access to prevention and wellness-promotion activities. Heart disease is the leading cause of death among women, and the community participants noted the importance of providing prevention and support services such as: focus on obesity, worksite wellness initiatives, outpatient diabetes education, and funding prevention. They stressed the importance of increasing awareness among providers and health plan participants of these health promotion benefits and services. Finally, another common health condition that impacts daily

living for adult women is pelvic floor disorders. The community participants emphasized a need to focus on screening and support services for these disorders.

Public Hearing
A formal public hearing was held on June 21, 2010. One member of the public attended. DCFHE credits excellent outreach and public participation prior to the public hearing as the reason for low attendance.

II. Needs Assessment

In application year 2011, the 2010 Needs Assessment will be attached to this Section II.

C. Needs Assessment Summary

The needs assessment summary is included in the needs assessment document.

III. State Overview

A. Overview

In order to develop and implement priorities for Rhode Island's Title V MCH Program, it is first necessary to understand the health needs of the state's entire population and the general health care delivery environment. Other issues, such as the geographical and cultural characteristics of a state and its localities (including their governmental structures) and economic and educational characteristics, also impact the health and human services needs of a population.

Equally important is an understanding of the key policy issues currently being debated in Rhode Island's public arenas. Current agenda items include tax relief, health care, jobs and economic development, education, affordable housing, and welfare reform. However, the state's safety net infrastructure has been damaged by cuts made in response to the fact that Rhode Island is now in an economic recession.

Rhode Island is awaiting results form the United State Census however, demographic data indicate that, by 2010, Rhode Island will be older, have fewer workers in their prime productive years, and be less self-sufficient, and more reliant on government assistance, requiring continued taxpayer investment in entitlement programs and fundamental public services. At the same time, the majority of state's voters believe that taxes are higher in Rhode Island than in other states and that the state is not doing enough to keep from raising taxes

Geographical & Cultural Characteristics

The state of Rhode Island is a small, coastal area (1,214 square miles) with just over one million residents (1,067,610). The entire state measures just 48 miles, from north to south, and 37 miles, from east to west. Historically, most Rhode Islanders have been White descendants of European immigrants, plus some long established African American families and members of the small Narragansett Native American Tribe.

With the establishment of the first water-powered cotton mill in the nation in Pawtucket in 1793, Rhode Island became the birthplace of the industrial revolution in the United States. Since then, waves of immigrants -- from the Italians, Irish, French/French Canadians, and Portuguese in the late 19th century to the Asians and Latinos in the late 20th century -- have come to Rhode Island in search of a better life.

Currently, 12.6% of Rhode Islanders are foreign-born, which ranks the state the 13th highest in the nation in this respect. Of the total foreign-born population in Rhode Island, 30.4% entered the state prior to 1980, 21.8% between 1980 and 1989, 24.7% between 1990 and 1999, and 23.1% in 2000 or later.

The largest share of the foreign-born population in Rhode Island is from Latin America (40.4%), followed by Europe (26.2%), Asia (15.3%), Africa (12.2%), and Northern America (5.5%). The top three counties of birth for Rhode Island's foreign-born residents are Portugal (14.1%), The Dominican Republic (13.5%), and Guatemala (9.3%). In 2005, 43.8% of the state's foreign-born residents were citizens.

The foreign-born make up 1.7% of young children in the state, 5.0% of youth, and 15.0% of working-age adults. Among people at least five years old living in Rhode Island in 2005, 20.4% spoke a language other than English at home. Of those speaking a language other than English at home, 48.7% spoke Spanish and 51.3% spoke some other language.

The three largest ancestral groups in Rhode Island are Italian, Irish, and French-Canadian. Rhode Island has a higher percentage of Italian Americans and persons of Portuguese ancestry, including Cape Verdeans, than any other state in the nation. Mainly due to large Irish, Italian, and French-Canadian immigration and, to a lesser extent, Portuguese, Puerto Rican, and Cape Verdean communities, Rhode Island has the highest percentage (63.6%) of Roman Catholics in the nation.

In 2006, there were 405,627 households in Rhode Island. The average household size was 2.5 people. Families make up 64.7% of the households in Rhode Island. This figure includes married-couple families (47%) and other families (17.7%). Rhode Island has the 7th lowest percentage of married-couple families living with their own children in the nation.

Although Rhode Island ranks high in percentage of forested land (60%), 75% of its population resides in a 40-mile long urban/suburban corridor along the shores of Narragansett Bay and in the valleys of the Blackstone and Pawtuxet Rivers. This corridor, which includes Providence, contains nearly all of the state's public infrastructure, major transportation routes, and institutional and cultural centers. Providence, the second largest city in New England after Boston, is a major metropolitan community in which an estimated 170,435 residents live.

Providence is one of Rhode Island's six (6) designated "core" communities, defined as being a city or town in which more than 15% of the children live in poverty. Rhode Island's other core communities include Pawtucket, Central Falls, Newport, Woonsocket, and West Warwick. Thirty-four (34.2%) percent of the state's population resides in these six core communities, where 37.3% of children under six (6) years and 33.9% of children under eighteen (18) years live below poverty.

According to the U.S. Census, the racial/ethnic distribution of Rhode Island's population in 2006 consisted of Whites (82.6%), Blacks (5.1%), Asians (2.8%), Native Americans (0.4%), Native Hawaiian or Pacific Islander (0.02%), those who identified themselves as being some other race (6.9%) and those who identified themselves as being two or more races (2.2%). From 1990 to 2000, Rhode Island's non-Hispanic White population declined by 4%. During the same period, the state's Black population increased by 21%, Asians by 31% and Native Americans by 26%.

Blacks represent the largest racial minority group (and the second largest minority group) in the state. Rhode Island's Black population became increasingly diverse during the 1990s as a result of increased immigration from Haiti, Cape Verde, Liberia, and Nigeria. Rhode Island's Liberian population, conservatively estimated at 15,000, constitutes the largest per capitol Liberian population in the United States. In addition, 10% of the Black population in the state is Latino, a large majority of which came from the Dominican Republic.

The state's Asian population grew by 31% during the 1990s. Most Southeast Asians immigrated to Rhode Island from the war-torn countries of Vietnam, Cambodia, and Thailand during the 1970s and 1980s. From 1975-1979, well-educated professionals escaped from Cambodia and after a brief stay in Thai refugee camps, were resettled in the United States (including in Rhode Island) and Canada. From 1979-1985, Cambodians continued to resettle, and larger numbers of rural agrarian families arrived in the United States, including Rhode Island. According to the 2000 U.S. Census, Rhode Island's Cambodian refugee population is the 7th largest in the United States.

The Native American population grew by 26% during the 1990s, consisting primarily of members of the Narragansett Indian Tribe. Native Americans live in Providence, Narragansett, North Kingstown, and Charlestown. The Narragansett Reservation near Charlestown currently is about 2,500 acres in size and has a population of about 2,500 residents, however, the actual number of Native Americans living in Rhode Island remains very small (5,389).
However, more striking than any other trend was the surge in the number of Latinos in the state. Latinos saw their numbers double in Rhode Island in the 1990s from 45,572 to 90,820, a pace double that found in Massachusetts. In 2005, Latinos made up 10.9% (112,722) of the state's population (an increase of 24% since 2000). Thirty six percent (36%) of Rhode Island's Latinos are children. The majority of Latinos in Rhode Island (63.9%) come from Puerto Rico (28%), the Dominican Republic (19.7%), Guatemala (9.9%), and Columbia (6.3%).

Rhode Island's children are diverse in race, ethic background, language, and country of origin. In 2006, there were 9,848 foreign-born children under age 18 living in Rhode Island, representing

4% of the state's child population. In Rhode Island, 78% of children ages 5-17 speak only English, 14% of children speak Spanish, 6% speak other Indo-European languages, and 2% speak Asian or other Pacific Island languages.

Of Rhode Island's immigrant children, 42% are from Mexico, Central, or South America; 29% from the Caribbean; 11% are from Europe; 11% are from Africa; and 6% are from Asia. Minority and immigrant children and their families are highly concentrated in the six core cities in Rhode Island. More than half (58%) of children living in the state's core cities are minority children. More than three-quarters (78%) of all minority children live in these six communities. Rhode Island has the highest percentage of Hispanic children living in poverty (79%) and fourth largest percentage of black children (71%) living in neighborhoods in which more than 18% of persons are in poverty in the nation.

According to the US Census, after gaining small numbers of people from other states from 2001 to 2003, Rhode Island began experiencing decreases in its population in 2004, with an estimated net loss of 2,114 people. In 2005, the estimate was a net loss of 11,618, and in 2006, a net loss of 12,566. Rhode Island was one of only four states to see its population decrease in the US Census Bureau's annual estimates in 2006. The decline in Rhode Island's population is being driven by the migration of young, college-educated people looking for better job opportunities and more affordable housing in other states //2009.

State & Local Government Structure

Rhode Island has advantages for effective public health program implementation, given its small geographical size and unique governmental structure. With the exception of the state court system, there is no county level of government in Rhode Island. The state is made up of 39 cities and towns ranging from 1.3 to 64.8 square miles in size. In Rhode Island, local communities possess control in areas such as primary and secondary education, subdivision of land and zoning, and housing code enforcement. A combination of cultural, socio-economic, and transportation-related factors makes "the neighborhood" the most important level of community in many parts of Rhode Island, especially low-income communities.

In preparation for the State Fiscal Year 2011 budget, the Governor proclaimed that the impact on the recession on the State of Rhode Island has been severe, with over 73,500 Rhode Islanders unemployed. Through December 2009, Rhode Island had a net loss of 42,500 jobs from January 2007, the peak of employment in Rhode Island. The jobless rate peaked at 13.0% in September and the State currently ranks third in the nation with a 12.9% of unemployment as of December 2009. The State has depleted the resources it set aside to pay unemployment benefits and is now borrowing from the Federal Trust Fund to make benefit payments to unemployed Rhode Islanders. The impact of the high level of unemployment has translated into a sharp decline in tax receipts to the State, as less personal income taxes are received from employers through withholding taxes, and taxpayers transmit lower estimated and final payments, but request larger refunds. The recession has also affected housing and spending, which generate the state's second largest source of income sales and use taxes. Public and private sector stakeholders are working to break this negative cycle and reverse the economic trend.

The Rhode Island Department of Health (HEALTH) is the sole public health authority that makes it legally responsible for the provision of core public health activities at both the state and local levels. HEALTH contracts with community-based organizations and professionals to provide nearly all direct preventive and public health services. The absence of local health authorities means that health care providers in the state look to the HEALTH for policy guidance and other forms of assistance. The state's Title V MCH Program is located in the HEALTH.

Economic Needs of the State's Population

In earlier generations, Rhode Island workers were well-paid and well-insured for health care

through the presence of its strong manufacturing base. However, many manufacturing jobs were lost in recent decades, and in the 1990s, Rhode Island experienced its worst recession since the Great Depression, losing 11.6% of its total job base. By 1992, Rhode Island's unemployment rate, at 9.1%, was the 4th highest in the nation.

After weathering the financial storms that battered the state in the early 1990s, Rhode Island rode a wave of economic growth in mid-1990s. Taking advantage of a strong economy, the state was able to reduce taxes, increase state spending by double and triple the rate of inflation, and still realize $100 million end of year surpluses. When the national economy faltered in 2001, most states were hit a lot harder than Rhode Island. The restructuring of Rhode Island's economy during the 1990s has been proposed as one of the reasons for Rhode Island's resilience during this period.

However, on April 28, 2008, Economy.com (which is owned by Moody's Investor Services) and the international consulting firm Global Insight informed state officials participating in Rhode Island's annual Revenue & Caseload Estimating Conference that Rhode Island stands alone as the only Northeastern state "in recession" and that the state's employment figures, foreclosure rates, and personal income growth are worse than its New England neighbors and national averages. It was noted that the state is just one of nine states in recession -- the next closest is Ohio. Rhode Island was the only New England state to report negative employment growth between March 2007 and March 2008.

The lack of affordable housing is a pressing problem in Rhode Island. A 2005 report by the National Low Income Housing Coalition found that Rhode Island faced a shortage of 11,000 housing units for residents earning 30 percent or less of the statewide median income, or $19,397 a year. Rhode Island ranks among the 10 least-affordable states in the country. Unfortunately, the state's affordable housing programs have been cut. The state's Neighborhood Opportunities Program ---- the seven-year-old fund that helps finance affordable housing for those who make less than $30,000 a year ----was allotted $5 million of their $7.5-million budget for FY2009. An additional $26 million was cut from Rhode Island Housing Corporation's budget for FY2009

RI also has the highest mortgage delinquency rate in New England. Rhode Island foreclosure rates have been rising since the end of 2005. In 2008, according to Rhode Island Housing Corporation data, of the nearly 3,000 properties in Rhode Island advertised for foreclosure during the 12-month period that ended March 31, 2008, 79% were in the cities and inner suburbs: Providence, Cranston, Johnston, East Providence and Warwick. Providence, with 1,543 foreclosure initiations, accounted for 52% of the total. Suburban and rural areas also experienced more foreclosures.

In Rhode Island, where house prices have increased ahead of growth in wages, 17% of households spent more than half their income on housing in 2005. Rhode Island is now one of 13 states -- including Massachusetts, Connecticut, and New Hampshire -- where more than half of all low-income households spend more than half of their income on housing. The disconnect between incomes and housing costs in Rhode Island is expected to persist into the next decade, as low-wage service jobs are added to company payrolls. Currently, a family with a household income of $51,814 (the median household income in 2006) cannot afford a median-priced, single-family home in any community in the state.

Educational Needs of the State's Population

According to RI Kids Count, the Rhode Island four-year graduation rate for the class of 2009 was 75%, the dropout rate was 14%, 5% of students completed their GEDs within four years of entering high school and 6% were still in school in the fall of 2009. Poverty is strongly linked to the likelihood of dropping out. Students in the core cities in Rhode Island are more than twice as likely to drop out of high school as students in the remainder of the state. Minority students also are more likely than White students to drop out of school. However, lower graduation rates in minority communities mainly are driven by higher poverty rates and lower rates of educational

attainment among adults in the community. The Rhode Island four-year graduation rate for the class of 2009 was 71% for males and 80% for females.11 While female students have lower dropout rates than males, national data show that female dropouts are significantly more likely to be unemployed and earn less on average than male dropouts from the same racial and ethnic group.

Rhode Island's education accountability system is designed to promote an increase in educational outcomes so all students reach proficiency by 2014, as required by the federal No Child Left behind Act of 2001. Schools are classified by their performance on 37 indicators by the Rhode Island Department of Elementary and Secondary Education. Classification levels include: "Insufficient Progress," "Caution," "Met Adequate Yearly Progress (AYP)," and "Met AYP and Commended." In Rhode Island in 2009, 225 schools (76%) were classified as "Met Adequate Yearly Progress (AYP)," 16 additional schools (5%) were classified as "Met AYP and Commended," 12 schools (4%) were classified as "Caution," and 44 schools (15%) were classified as making "Insufficient Progress." Schools that do not miss any current targets are classified as "Met AYP." Schools that achieve exceptionally high performance in English or Mathematics for two years, make significant progress for two years or significantly closed achievement gaps between student groups are designated as Regents Commended Schools ("Met AYP and Commended"). Schools that miss up to three targets for the first time (other than school-wide English and mathematics targets) may be classified as "Caution" for one year only. Schools that miss a school-wide English or math target, more than three targets, or schools that miss any target for multiple years are classified as making "Insufficient Progress." Schools that are classified as making "Insufficient Progress" may face state interventions, including the implementation of a corrective action plan or restructuring by the state.

Until 2010, Rhode Island was the only State in the nation without a school funding formula. This year, the RI State Legislature passed and Governor Carcieri signed into law a statewide funding formula. The funding provides a base funding that follows the child and provides additional funding for children with special needs including health concerns and poverty levels.

In 2000, 78% of Rhode Island adults had a high school diploma. The proportion of residents age 25 and older with at least a high school diploma is the smallest among the six New England states, and the proportion with at least a four-year college degree is the second worst - ahead of only Maine. In 2006, Beacon Hill Institute gave Rhode Island a competitiveness ranking of 36th worst of 50 states on its "percent of population aged 25 years and above that graduated from high school." Currently, almost 44% of workers in the state have a high school degree or less.

According to the Rhode Island Economic Policy Council (RIPEC), an advisory panel made up of leaders in government, education, and business, the average level of education in the state is declining at the same time that the skills required by employers are rapidly increasing. Of Rhode Island's one million residents, 142,000 adults lack a high school diploma and 35,500 have limited English language skills. By 2010, the share of the workforce that has not graduated from high school is expected to increase in Rhode Island, while the percentage of workers who have graduated from college, including those with a graduate degree, will drop, according to data from the National Center for Public Policy and Higher Education.
According to the Nellie Mae Foundation, the percentage of young workers in Rhode Island holding a bachelor's degree or higher will drop by 3%-4% by 2020 since Blacks and Hispanics (the fastest growing demographic groups in the state) have not been making the gains necessary to compensate for the exodus of Whites. Further, nearly half of all new college enrollments in Rhode Island originate from out of state (more than any other New England state) and many of these students choose to leave the state when they graduate.
Social Service Needs of the State's Population

Economic forces and the educational needs of a community, coupled with the demographic and cultural characteristics of the population, impact the social service needs of individuals and families. In 2005, 12% of Rhode Island's population lived in poverty. Although this percentage is

comparable with the percentage for the nation as a whole (13%), it is higher than every other state in New England.

In 2006, the proportion of children under age 18 as a proportion of the population in poverty in Rhode Island was 15.1%, which was lower than the nation (18.3%). Rhode Island ranked 17th in the nation and 5th in New England, whereas only 9% of White children in Rhode Island live in poverty, 36% of Black children, 36% of Hispanic children, and 14% of Asian children live in poverty.

The Family Independence Program (FIP) is the state's welfare reform program, as set forth in the Rhode Island Family Independence Act of 1996. FIP seeks to help low-income families by providing the supports (including subsidized health insurance, childcare, and work-readiness activities) that families need in order to obtain and keep a job. Between 1996 and 2007, there was a 46% decline in the state's FIP caseload, from 18,428 cases to 9,993 cases.

As of December 2007, there were 6,242 adults and 17,808 children under the age of 18 enrolled in FIP. Three-quarters (74%) of all FIP beneficiaries were children under the age of 18. More than 2 in 5 (44%) children enrolled in FIP were under the age of six. In Rhode Island, 77% of the families enrolled in FIP have one or two children.

Rhode Island, under the childcare law (Starting Right), is the only state that has a legal entitlement to a childcare subsidy for income-eligible working families. Until 2007, working families with incomes up to 225% of the federal poverty level were entitled to a childcare subsidy for their children up to age fifteen. Co-payments were required for families with incomes over the federal poverty level. In 2007, eligibility for child-care subsidies was reduced from 225% of the FPL to 180% and the age eligibility was rolled back to age 12. Rates to providers have been frozen since 2004 at the 2002 market rate level. These changes resulted in the removal of 1,743 children from Starting Right in 2007. In 2007, the number of children receiving subsidies dropped to 9,008.

Currently, Rhode Island is the 5th least affordable state in a United States for a 4-year old in a child- care center. In Rhode Island, the average cost of full-time child-care for a preschooler consumes 45% of the median single parent family income and 10% of the median two-parent family income. Using the federal affordability guideline that families should spend no more that 10% of their gross income on childcare, a Rhode Island family would need to make at least $87,000 a year to afford the average cost of child-care for a 3-year old at a licensed center ($8,736).

The shortage of affordable apartments and increasing energy costs in the state is causing an increasing number of Rhode Islanders to seek shelter in the state's emergency shelter system. For the fifth year in a row, Rhode Island's emergency shelter system provided record nights of refuge to more people in 2006 (6,889 individuals) than the previous year. The number of families seeking shelter has increased 50% since 2000/2001. Eighteen percent (18%) of the 5,511 adults who entered the shelter system in 2006 entered as adults with families. Twenty-percent (20%) of the 6,889 individuals who entered the shelter system were children (1,378).

Health Care Needs of the State's Population

Rhode Island enjoys the second highest prenatal care rate (90.9%), the 4th lowest obesity rate (17%), the third lowest child death rate (15 per 100,000 children), the second lowest teen death rate (31 per 100,000 teens), the fifth lowest firearms death rate 5.1 per 100,000 population), the sixth lowest per capita rate of suicides (0.078 per 1,000 population) in the nation.

Unfortunately, it also has the third highest rate of cancer incidence (510.5 per 100,000 population) and the third highest homicide rate for victims aged 18-24 years (34.1%). Among people at least five years old in 2005, 16% reported a disability. The likelihood of having a

disability varied by age -- from 9% of people 5-20 years old, to 13% of people aged 21-64 years old, and to 39% of those 65 years and older.

Rhode Island filed and was granted a waiver for comprehensive Medicaid reform, which would set aside many traditional Medicaid requirements for up to five years, with the promise of substantial savings to help deal with the state's "structural deficit". Since much of the current MCH system is built on RIte Care plan services, and on targeted case management, many advocates and partners are worried about the "global waiver" plan. The RI Department of Health participates in governance groups related to the implementation of the Global Medicaid Waiver resulting in the expansions of EPSDT standards to include oral health, developmental and autism screening, and other provisions of Bright Futures 3.0. It is vital to keep up MCH data and input channels (KIDSNET, PRAMS, TWOS, etc) to monitor and manage impacts on vulnerable children and families.

Economic trends, and the educational and social services needs of a community, coupled with the demographic and cultural characteristics of the population, impact the health care needs of individuals and families. In 1979, 74.4% of working Rhode Islanders had employment-based health insurance. By 2003, only 57.1% of workers received coverage through private employers.

The state's Medicaid managed care program, RIte Care, has had a profound impact on the state's health care system. Three carriers participate in RIte Care. Neighborhood Health Plans of Rhode Island (NHPRI) has a market share of 59% and UHPNE controls 29%. The remainder of the market (12%) consists of BCBSRI through its Blue Chip Program. The majority of NHPRI's clients access services through the state's community health center network, while UHCNE and BCBSRI clients access services through private providers or hospital-based clinics.

According to RI Kids Count, between 2006 and 2008, 7.0% of Rhode Island's children under age 18 were uninsured, compared to 10.8% of children in the U.S. Rhode Island ranks 14th best in the nation with 93.0% of children with health insurance, down from 2nd in 2002 and 2003. The majority of children in Rhode Island are covered by private health insurance, most of which is obtained through their parents' employers. An estimated 4,983 uninsured children under age 19 live in Rhode Island families with incomes at or above 250% of the federal poverty level ($44,000 for a family of three in 2008), the limit for RIte Care eligibility. Between 2006 and 2008, approximately 72% (13,078) of the estimated 18,141 uninsured children in Rhode Island were eligible for RIte Care based on their family incomes but were not enrolled. Recent increases in the rate of uninsured children in Rhode Island can be partly attributed to the decline in employer-sponsored insurance. Between 2006 and 2008, 67.2% of children were covered by employer-sponsored health insurance (ESI), down from 73.3% between 1999 and 2001 (an 8% decline). The cost of health care coverage for families has increased faster than wages in every state over the past decade. Between 1999 and 2009, health care premiums in Rhode Island increased by 122%, compared with 38% wage growth.16 In 2008, the average annual cost for a family policy in Rhode Island was $13,363, compared with $12,298 in the U.S. Rhode Island's RIte Share premium assistance program helps low-income families to afford the cost of employer-sponsored coverage. RIte Care provides coverage to children up to age 19 in families with incomes up to 250% of poverty. RIte Care also covers parents of eligible children in families with income up to 185% of poverty. RIte Care expanded eligibility to include pregnant women up to 350% of poverty and childcare providers who serve low-income children. As of December 31, 2007, 70% (77,054) of the RIte Care members who qualified based on family income were children under age 19. There were 39,186 low-income parents enrolled in RIte Care as of December 31, 2007. Of these parents, 16% (6,242) received RIte Care because they were enrolled in the Family Independence Program (FIP).

In April of 2001, the Rhode Island Department of Human Services (HEALTHS) launched the RIte Share initiative as a way to control increasing costs associated with RIte Care and to strengthen the employer-sponsored health insurance infrastructure in the state. RIte Share requires RIte Care applicants with access to employer-sponsored insurance to participate in their employer's

insurance plan. RIte Share pays the employee's share of the cost for enrolling in an approved employer-sponsored family or individual health insurance plan. Eligibility guidelines are the same as for RIte Care. RIte Share provides the full range of RIte Care benefits to families by covering RIte Care services not included in the employer's health insurance plan. As of December 31, 2009, 7,234 children and 3,143 parents (10,377 total) were enrolled in RIte Share.

Rhode Islanders with the highest un-insurance rates are young adults ages 18-34 years (18.5%), adult males ages 16-64 years (12.8%), adults living in families without children (12.6%), adults with family annual incomes less than $25,000 (23.1%), and unemployed adults (30.4%). However, the rise in un-insurance in 2003 compared to the previous year is seen primarily among young adults (a 10.1% increase), women (a 15.5% increase), families with children (a 5.8% increase), middle-income households (a 34% increase), and the employed (a 9.2% increase). Uninsured Rhode Islanders access services through the state's CHC network and through hospital emergency rooms.

Over 40% of Rhode Island adolescents aged 12-21, with private health insurance, did not receive an annual preventive care visit. Although RI does better that the national benchmark of 59% for private health plans, the numbers indicate that adolescents are not receiving preventative services on a regular and consistent basis.

Rhode Island's emergency room current utilization rates exceed the United States and Northeast averages by 4% and 9%, respectively. Based on these rates and the projected population, emergency room visits in Rhode Island will total 460,000, nearly 30,000 more emergency room visits as compared to 2000. As expected, young working age individuals (18-44 years), including the uninsured, comprise the largest population (44%) of these visits. In the absence of a state-supported hospital, all of the hospitals in the state are legally mandated to treat the uninsured.

With respect to mental and behavioral health needs of the state's population, the rate of non-federal acute hospital discharges with a principal diagnosis of a mental disorder, including substance abuse (MD/SA), was substantially higher in Rhode Island (11.9 per 1,000 population) than nationally (7.7) in 2004. The total number of discharges with a principal or secondary diagnosis of MD/SA comprised more than one-quarter (27.7%) of all discharges (excluding newborns) from these facilities. This data indicates that hospitalizations of persons with a diagnosis of MD/SA comprise a large proportion of the inpatient care provided in Rhode Island's hospitals. The majority of such patients have an MD/SA diagnosis secondary to a principal diagnosis of a physical illness or injury.

National Survey on Drug Abuse & Mental Health data (2004) seems to support that Rhode Islanders experience higher rates of substance abuse and serious psychological distress compared to other New England states. Rhode Island has the highest percentages of past year any illicit drug dependence or abuse (3.49%), past year cocaine use (3.52%), past year alcohol dependence or abuse (9.59%), and past year serious psychological distress (12.18%). It also had the highest percentages of individuals needing but not receiving treatment for illicit drug dependence or abuse (3.06%) or alcohol dependence and abuse (8.91%). Rhode Island also has the highest percentage of alcohol related traffic fatalities (50%), the second highest percentage of heavy drinkers (7.3%), the third highest percentage of binge drinkers (18.2%) in the nation.

In Rhode Island, private insurance rates for behavioral health services were reduced in the 1990s, and although rates for some services have been increased, many behavioral health services have yet to be adequately reimbursed. Public services have generally not been adequately funded to meet the needs presenting to the system.

Publicly funded mental health services for children in Rhode Island are provided by the state Department of Children, Youth, and Families (DCYF) through contracts with community-based organizations or through RIte Care. Mental health care for adults is provided by the state Department of Mental Health, Retardation, & Hospitals (MHRH) directly or through RIte Care.

Low-income, uninsured individuals are dependent upon the state's community mental health system for services.

In 2006, the National Alliance on Mental Illness (NAMI) gave Rhode Island an overall grade of "C" with respect to its progress toward ensuring a proven, cost-effective mental health system, based on information from four information sources and scored from 39 specific criteria representing four categories: Infrastructure, Information Access, Services, and Recovery Supports. According to NAMI, Rhode Island's urgent mental health needs include: private sector provider rates and supply, alternatives to hospitalization, and Spanish language workforce development.

Dental insurance is not available to many working families in Rhode Island. Fewer than half (48%) of Rhode Island employers offer dental insurance to their full-time employees, and 14% offer it to there part-their employees. Despite this, the percentage of Rhode Islanders who had a dental visit within the past year was 78.5% in 2004, which ranked Rhode Island 4th highest among the 50 states. State law requires schools to provide dental screenings for all newly enrolled students, annually for children in grades K through 5, and at least once between grades 7-10.

In 2006, Medicaid reimbursement rates were raised for dental providers participating in the RIte Smiles Program. As a result, the number of dentists accepting qualifying children with Medical Assistance has more than tripled. Nearly half (49%) of children who were enrolled in RIte Care, Rite Share, or Medicaid fee-for-service during 2006 received a dental service during the year.

Fourteen percent (14%) of Rhode Island children under age 18 are estimated to have special health care needs. Currently, 23% of all households in Rhode Island have a child with at least one special health care need. A higher percentage of children in low-income families in Rhode Island have special health care needs compared to those in the United States, with 16% of Rhode Island children in families with incomes less than 200% of the federal poverty level reporting special health care needs, compared with 14% nationally.

Rhode Island is required under Part C of the federal Individuals with Disabilities Education Act (IDEA) to provide appropriate Early Intervention services to all children from birth to age three who are developmentally delayed or have been diagnosed with a physical or mental condition that has a high probability of resulting in developmental delay. Recent changes to the federal legislation requires states to refer children who have been involved in a substantiated case of child abuse or neglect and children who have been affected by illegal substance abuse to EI for an eligibility assessment. In addition, Rhode Island's eligibility criteria include children who are at-risk of experiencing a substantial delay if early intervention services are not provided through a multiple established conditions category (very few states choose to provide services to at-risk children).

In Rhode Island in 2009, ten certified Early Intervention provider agencies served 3,795 children. Nearly two-thirds (63%) of children receiving Early Intervention services were male and just over one-third (37%) were female. Enrollment is nearly evenly distributed among children by age, with 31% ages birth to one year, 35% between ages one and two, 33% between ages two and three, and less than 1% over age three. Children living in Rhode Island's core cities were almost twice as likely to participate in Early Intervention based on multiple established conditions (10.4%) than children in the remainder of the state (6.1%).

In Rhode Island, local school systems are responsible for identifying and evaluating students ages 3-21 who they have a reason to believe are students with disabilities and therefore might require special education and related services through IDEA. Between school year 1990/1991 and school year 2005/2006, the percentage of students enrolled in special education increased by 49% in Rhode Island. In school year 2004/2005 (the most recent year national data were tabulated), Rhode Island had the highest percentage (20%) of public school students identified as disabled and receiving special education services under IDEA in the nation.

In Rhode Island during the 2008-2009 school year, 17% (24,302) of children enrolled in K-12 public schools received special education services. Forty-one percent (41%) of students receiving special education services in Rhode Island had a learning disability.

Children who meet certain disability criteria are eligible for Medicaid and/or cash assistance through the federal Supplemental Security Income (SSI) Program. In 2006, there were 5,175 Rhode Island children under age 21 receiving Medical Assistance benefits because of their enrollment in SSI. In Rhode Island, the Katie Beckett eligibility provision provides Medical Assistance coverage to certain children who have serious disabling conditions, in order to enable them to be cared for at home instead of an institution. In 2005, there were 1,562 Rhode Island children under age 21 enrolled in Medical Assistance because of eligibility through the Katie Beckett provision.

Childhood obesity continues to be a crisis in RI. 36 percent of our WIC children are overweight or obese, as are 40 percent of our 7th graders and 27 percent of our high school youth. The situation is worse in urban areas where the built environment, and social and political influences make it hard for families to make healthy decisions. ARRA stimulus funds provide a unique opportunity for HEALTH to partner with non-traditional partners to address issues around community walkability, recreation, urban planning, zoning and access to affordable healthy foods. RI's tobacco control movement has successfully resulted in passage of smoke free work place laws and other legislation restricting the sale and promotion of unhealthy tobacco products. Lessons learned from these successes are informing legislative and community mobilization strategies in RI to reverse the unhealthy trends in overweight and obesity.

Pandemic Influenza 2009/20010
The importance of a strong and sustainable infrastructure for maternal and child health was well demonstrated this past year with the pandemic flu outbreak. It can be noted that because of the infrastructure that has been built in and with Title V, our immunization rates for our children and pregnant women greatly surpassed our neighboring New England states. Per the BRFSS 2009-2010 we achieved an 85% rate of immunization for infants, children and young adults and a rate of 67% for our pregnant women.

State Title V Priorities

This past year was marked with unprecedented challenges that affected the Division of Community Family Health and Equity as well as the entire RI Department of Health, from programmatic issues, to budget constraints, workloads and job responsibilities that shifted associated with the worldwide H1N1 pandemic, ARRA funding to states and health reform passage. Daily contribution s and commitment of HEALTH staff was key in meeting the Department's priorities including: reducing health disparities and achieving health equity, addressing the epidemic of obesity and the creation of policies, social and built environments that makes adoption of healthful choices the easiest and preferred option. The Department's Division of Community, Family Health and Equity (DCFHE) supports these department-wide priorities as well as being the lead Division for Maternal and Child Health priorities.

The DCFHE has primary responsibility for assessing the health and developmental needs of young families and children in the state, for planning effective measures to address those needs, for evaluating programs and policies affecting the health and development of women, children, and families in the state and for implementing effective measures to address those needs. DCFHE's new approach to public health includes the four pillars of: equity, the social and environmental determinants of health, life course approach, and integration. When allocating resources and making decisions on what interventions should be implemented, CFHE uses the "Equity Pyramid" -- adapted from Thomas Frieden, MD, MPH, presentation at the Weight of the Nation Conference, in Washington D.C., July 27, 2009- as a tool to help prioritize its work. The "Equity Pyramid" establishes 5 levels of program impact/effectiveness from Level 1 (less impact)

at the top of the pyramid to level 5 (most impact) at the bottom at the pyramid. As you go up the pyramid the interventions impact the individual, but have less of an impact across the population.

During this Title V MCH needs assessment year, the DCFHE identified new priorities informed by data collection and surveillance, family and community input, and interagency collaboration. State Performance Measures 2-6 mirror the identified priorities reflected in the themes based on data and community input. State Performance Measures 1, and 7 are related priorities based on a life course perspective for prioritizing health care needs and services by looking at health and wellness across the lifespan. The measures are for specific populations yet our intent and purpose is an overarching priority across all of the MCH population groups. State performance measures 8 and 9 are indicators of the social determinants of health. Most health disparities affect groups that are disadvantaged or marginalized because of their socioeconomic status, race/ethnicity, gender, sexual orientation, disability status, geographic location, or any combination of these. Access to healthy food and quality education are social determinants that contribute to good health. A chart reflecting the MCH populations, themes form community input, priorities and performance measures is in an attached document. In FY2011, the DCFHE developed the following priorities and measures for action under Title V:

Priority: Expand capacity and access to parent education and family support programs.
SPM1: Percent of RI resident families with at-risk newborns that receive a home visit during the newborn period (<=90 days).

Priority: Reduce tobacco initiation among middle school students.
SPM2: Percent of middle school students who have initiated tobacco use.

Priority: Increase the percentage of adolescents who have a preventive "well care" visit each year.
SPM3: Percent of adolescents who have a preventive "well care" visit each year.

Priority: Increase the social and emotional health of children and youth with special health care needs.
SPM 4 Percent of high school students with disabilities who report feeling sad or hopeless.

Priority: Increase the percentage of women who have a preventive care visit in the last year.
SPM 5: Percent of women who have a preventive care visit in the last year

Priority: Initiate prenatal home visiting program.
SPM6: Percent of pregnant women delivering babies served by home visiting.

Priority Promote use of evidence based programs to support parents and families
SPM 7 Number of parents with children in early childhood that enroll in parenting education/support programs.

Priority: Adopt the social determinants of health into public health practice.
SPM 8: Percent of Rhode Island adolescents who report food insecurity.
SPM 9: Percent of Rhode Island high school students who earn a high school diploma or diploma equivalent in the six core cites.

Through ongoing partnerships with community advocates, providers, and the families we serve, the DCFHE is committed to realizing these priorities and ensuring that all families in our state have the opportunity to raise safe and healthy children in safe and healthy communities.

An attachment is included in this section.

B. Agency Capacity

Chapter 23-13 of the RI General Laws (1937, 1999) designates the RI Department of Health (HEALTH) as the state agency responsible for administering the provisions of Title V of the federal Social Security Act in RI relative to MCH services. As the recipient of the state's federal Title V MCH block grant funds, HEALTH's Division of Community, Family Health & Equity (DCFHE) plays an important role in addressing the MCH needs of children including those with special health care needs and their families in RI. Assuring optimal growth and development, detecting health problems early, and instilling skills for positive healthy behaviors have beneficial effects over the life course.

In 2008, the RI Department of Health underwent a significant reorganization. The intent was to promote synergy among programs as described in the Organizational Structure section of this application. The reorganization provided an opportunity for DCFHE to align programs to achieve better synergy, coordination and integration to meet the goal of achieving health equity for all Rhode Islanders through eliminating health disparities, assuring healthy child development, preventing and controlling disease, preventing disability, and working to make our environment healthy. Finally the reorganization has enabled HEALTH to leverage limited resources to better address the public health needs of communities.

DCFHE uses a lifecourse development approach that addresses the determinants of health as its framework for health planning. Social, political and economic polices and conditions evolve and determine health outcomes. While, HEALTH has made significant progress in meeting Title V measures and Healthy People 2020 goals, disparities still exist. Therefore, proactive and applied public health strategies focus on all members of the community to eliminate health disparities in Rhode Island. It is through this collective work effort that DCFHE offers quality programs and continues to assure that all Rhode Islanders will achieve optimal health throughout the lifespan via a statewide system of services that are comprehensive, community-based, coordinated and family-centered. This approach links with the MCH needs assessment to form the basis of our work in this application.

Children and Youth with Special Health Care Needs

The Office of Special Health Care Needs (OSHCN) is the designated Title V Maternal and Child Health Office of Children with Special Health Care Needs, and is mandated to "provide and promote family-centered, community-based, coordinated care for children with special health care needs, and facilitate the development of community-based systems of services for such children and their families."

RI is a 1914 A state (i.e. all children participating in the Supplemental Security Income program receive Medicaid benefits which includes rehabilitative services). The DCFHE convenes the SSI State Team, participates in the Rhodes to Independence Medicaid Infrastructure Steering Committee, the Global Medicaid Waiver State Implementation Team, and the Family Voices Leadership Team to ensure a safety net for children eligible for SSI and their families. The Team includes representatives from the state departments of Health, Education, Human Services, Children, Youth and Families and other organizations such as the RI Parent Information Network, RI Family Voices, and Hasbro Children's Hospital.

The DCFHE and its OSHCN facilitates the development of community-based systems of services for CYSHCN and their families, which focuses mainly on infrastructure building activities. The DCFHE is in a unique position to advocate with families raising CYSHCN to coordinate statewide

services and to provide leadership for the special needs service delivery system, especially as it relates to access to and quality of pediatric specialty services, educating children with special needs, child welfare prevention, and mental/behavioral health. DCFHE invests in the special needs infrastructure through parent support and empowerment opportunities and the provision of quality assurance through a special needs leadership council.

Assuring Culturally Competent Care

The DCFHE is committed to ensuring that services are culturally competent. RI has one of the highest percentages of foreign-born residents in the nation and 20% of RI residents are a racial or ethnic minority. Over the last ten years, DCFHE staff has become increasingly diverse. The majority of parent consultants employed through the DCFHE are from diverse backgrounds. Information and educational materials are written at or below a sixth grade reading level and most materials are available in English and Spanish, with a limited selection available in other languages (Portuguese, French, Lao, Khmer, Russian, Chinese, Hmong) based on program needs.

Reducing racial and ethnic disparities is a priority. HEALTH has been working with all its partners to raise awareness of and increase adherence to the National Standards for the Provision of Culturally and Linguistically Appropriate Services in Health Care Settings (CLAS Standards). The DCFHE supports the delivery of culturally competent care through data collection, analysis and reporting specific to racial and ethnic groups. HEALTH has a data policy that requires all departmental data sets to collect, analyze, and report data by race and ethnicity to inform program planning, professional development, and policy development. The DCFHE supports many community-based initiatives throughout RI, including in the core cities, directing resources where a large number of ethnic and racial minorities reside.

State Statutes Relevant to Title V

RIGL 16-21-7 (1938, 2009) requires local schools to have a school health program including health education, health services and healthy school environment, that is approved by HEALTH and RIDE.

RIGL 23-5-20.5 (2002) establishes standards for the maintenance of pre-1978 rental property in RI and provides property owners with access to liability coverage for lead poisoning.

RIGL 23-1-18 (1966, 1993) authorizes HEALTH to require the reporting of immunization status for the purpose of establishing and maintaining a childhood immunization registry for children under the age of 18 years.

RIGL 23-1-43 (1992) requires the Director of Health to establish a minority population health promotion program to provide health information, education, and risk reduction activities to reduce the risk of premature death from preventable disease in minority populations.

RIGL 23-1-44, (1991, 2006) requires HEALTH to provide all routine vaccines for children and adults.

RIGL 23-1-45 requires Rhode Island insurers to provide funding for vaccines for insured children and adults.

RIGL 23-6-0 (1989) authorizes HEALTH to require HIV screening and testing of adolescents, adults and pregnant women.

RIGL 23-1-49 (1985, 1997) authorizes HEALTH to establish and maintain registries for traumatic brain and spinal cord injuries.

RIGL 23-13-3 (2003) creates a birth defects surveillance registry.

RIGL 23-13-13 (1979) requires all newborns to be screened for hearing impairments.

RIGL 23-13-14 (1987, 2001) requires all newborns to be screened for metabolic, endocrine, and hemoglobinopathy disorders.

RIGL 23-13-16.1 (1988) requires hospitals to submit statistics relating to the annual rate of caesarian sections, primary and repeat, to HEALTH.

RIGL 23-13-17 (1987 & 1996) designates HEALTH as the state agency for administering the provisions of the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) Program.

RIGL 23-13-20 (1988) authorizes HEALTH to establish a family life and sex education program to assist in the establishment of community networks in the maternal and child health planning areas with high rates of teenage pregnancy.

RIGL 23-13-21 (1988) authorizes HEALTH to establish a payer-of-last-resort program to cover the costs of outpatient family planning counseling and comprehensive reproductive health services for men and women who are uninsured and ineligible for Medicaid in RI.

RIGL 23-24.6 (1991) authorizes HEALTH to establish a comprehensive statewide program to reduce the prevalence of childhood lead poisoning in the state.

RIGL 40-19.1 (1997) requires HEALTH, the RI Department of Human Services (DHS), the RI Department of Children, Youth, & Families (DCYF), and the RI Department of Education (RIDE) to develop a comprehensive statewide plan to prevent and reduce the incidence of unwanted pregnancies among adolescents in RI.

Collaboration With Other State Agencies & Private Organizations
The DCFHE works closely with other state agencies, community providers of health services, and constituent groups to promote the healthy development of women, infants, and children, including CYSHCN.

The Statewide Breastfeeding Coalition has had an impact on breastfeeding support both in the community and at the legislative level. WIC collaborates with W&I hospital to support breastfeeding in the NICU and throughout the hospital for WIC eligible clients. The WIC Breastfeeding Coordinator works closely with the staff of the Initiative for a Healthy Weight to promote Breastfeeding in the workplace and promoting baby friendly hospitals in RI.

The Successful Start Advisory Board is comprised of approximately 20 community members and state agency representatives. This committee is responsible for helping to implement RI's early childhood comprehensive systems plan.

The Women's Health Advisory Committee advises the Department of Health & Office of Women's Health on statewide priorities and policies. It envisions a Rhode Island where women live to their optimal level by achieving an ideal state of health by promoting a gender-informed, coordinated, comprehensive, primary prevention approach to women's health across the lifespan. Work is targeted to eliminate health disparities across all dimensions of age, ability, geography, race, ethnicity, sexual orientation, economics and education.

The Minority Health Advisory Committee to the Director of Health is comprised of approximately twenty community members. It provides a forum for racial/ethnically diverse community experts to review and evaluate progress in reducing health disparities and implementing policies and programs to improve health outcomes of minorities across all settings.

RI Department of Human Services (DHS): HEALTH has a formal Medicaid agreement with DHS for Early Periodic Screening, Diagnosis and Treatment (EPSDT) services. It also has memoranda of agreement with DHS to: share data related to KIDSNET, lead screening rates and asthma; support the Early Intervention Child Find mandate; involve their vendor EDS as pharmacy benefits manager of the AIDS Drug Assistance Program, Staff from HEALTH provide consultation and professional expertise to DHS in the areas of assessment, assurance, and policy development through formalized workgroups and program specific discussions to target outreach and program efforts.

The DCFHE also works collaboratively with DHS in the administration of the state's care coordination system for CYSHCN (CEDARR), the provision of services through the Early Intervention program, statewide access to screening and assessment for children with complex special health care needs, Viral Hepatitis B and C prevention efforts, and the administration of parent engagement and support activities in clinical practices (PPEP). The DHS and the OSHCN collaborate on family engagement programs, parent leadership and stakeholder initiatives. The DCFHE and DHS also jointly manage and fund the Child Care Support Network. DHS is a full partner in the implementation of Successful Start, RI's Early Childhood Comprehensive Systems initiative. DHS collaborates on DCFHE's Oral Health for Pregnant Women initiative to increase the number of pregnant women on RIte Care who visit a dentist during their pregnancy, encourage the integration of primary and oral health care and to improve birth outcomes of Medicaid recipients.

RI Department of Education: RIDE is a key partner in the implementation of RI's Early Childhood Comprehensive Systems Plan. The OSHCN collaborates with RIDE on implementing and assuring access to special education through the Parent Information Network Resource Center, assisting families through the PPEP and providing workshops and technical assistance for families and school districts. RIDE also partners in the implementation of the PPEP program and assists families in understanding their rights in the special education system. RIDE and OSHCN partner on autism initiatives including the screening, diagnosis and education of children and youth with autism spectrum disorders. The OSHCN is a member of the RIDE led Transition Council Special Education Advisory Council. RIDE continues to collaborate with DFCHE on thrive, RI's coordinated school health program through maintenance of a joint website including RIDE and DFCHE contacts as appropriate. RIDE, DCFHE, and HEALTH's Center for Data and Evaluation administer the Youth Risk Behavior Survey every other year in RI high school and middle schools and produce reports linking key health indicators and academic achievement along with reports that illustrate the disparities in health across key populations including children with physical, emotional and/or learning disabilities and children who identify as gay, lesbian, bisexual or unsure. HEALTH participated with RIDE in the development of a new survey for students, parents in teachers related to factors involved in teaching and learning including health issues. Since 2001, HEALTH has collaborated with RIDE to provide catch-up vaccinations to high school students through the Vaccinate Before You Graduate Program (VBYG). Beginning in 2011, HEALTH will partner with RIDE to implement a statewide school based influenza immunization program. DFCHE collaborated with RIDE to prioritize asbestos inspections in schools located in Environmental Justice Areas as defined by EPA. DCFHE participated in monthly meetings with the RI School Building Maintenance Director's Association, strengthening partnerships and communication regarding the Asbestos Hazardous Emergency Response Act requirements and responsibilities.

RI Department of Children, Youth & Families: The DCFHE is collaborating around data sharing via KIDSNET to better coordinate preventive health care for children in foster care. The DCFHE First Connections Home Visiting Program is working with DCYF in the implementation of new regulations regarding screening young children with substantiated cases of child abuse/neglect for Early Intervention eligibility. First Connections nurse home visitors perform screening and serve as a liaison between DCYF and Early Intervention providers. DCYF is a full partner in the implementation of RI's Early Childhood Comprehensive Systems Plan. OSHCN partners with

DCYF and DHS on the design and implementation of the children's behavioral health system in RI. OSHCN convenes and sponsors opportunities for family involvement and stakeholder participation in the children's behavioral healthcare system. The DCFHE participates on the Children's Trust Fund, which administers the state's primary and secondary prevention of abuse and neglect. The Initiative for Healthy Weight collaborates with DCYF around improving nutrition requirements for licensed childcare providers.

RI Department of Environmental Management: The DCFHE collaborates with DEM's Division of Agriculture in the promotion, support and monitoring of the WIC Farmers Market Nutrition Program. HEALTH and the RI DEM collaborate on reducing hazards from exterior lead paint and from asbestos. DCFHE worked in partnership with DEM, the RI National Guard and the EPA Region 1 Criminal Investigation Unit on several investigations regarding asbestos related compliance.
RI SNAP Committee: This DHS sponsored committee engages community partners, including DCFHE, in monitoring the success of outreach and service provision of the SNAP Program in RI.

Department of Transportation has a cooperative agreement with DCFHE's Initiative for a Healthy Weight for improvements in community built environments to encourage active transportation.

Children's Neurodevelopment Center at Hasbro Children's Hospital (CNDC) provides specialty and sub-specialty services to medically complex CYSHCN from birth to 21 years of age, including infants identified through newborn screening and is a DHS certified CEDARR Family Center. The CNDC addresses issues relating to quality of care, identification of services, access to reimbursement and family centered practices. Two parent consultants work with the CNDC. The CNDC has access to KIDSNET to assure proper preventive services and coordination of care.

RI Hearing Screening Assessment Program (RIHAP):at Women & Infants Hospital provides support and follow-up for children with hearing impairments identified through the newborn screening process. The DCFHE participates on RIHAP's Hearing Screening & Follow-Up Committee. DCFHE recently completed a Resource Guide for Families of Children Who Are Deaf or Hard of Hearing including algorithms for medical homes and families to explain newborn hearing screening.

RI Transition Council: The DCFHE continues to participate on the RI Transition Council, which was established by state statute to coordinate the activities of state agencies and school districts for youth with disabilities transitioning from school to adult life. The OSHCN developed an adolescent healthcare toolkit that is being used by the members of the Transition Council and their organizations.

RI Family Voices works closely with DCFHE and is a member of the SSI Team and assists in the administration of the PPEP. RI Family Voices implemented a Family-to-Family Health Information Center, funded under Medicaid and MCHB. The Family Voices Leadership Team comprised of leadership from state agencies, community organizations, and service providers addresses barriers to a coordinated CYSHCN service delivery system.

School and Child Care Provider are offered training and technical assistance by the Office of Immunization to ensure that all children are up to date on their required vaccines.

The RI Oral Health Commission seeks to improve the oral health status and reduce disease disparities among children by promoting effective oral health habits, expanding oral health and disease prevention knowledge, and advocating for improved access to oral health services.

RI Parent Information Network (RIPIN), a statewide, non-profit agency, provides information, training, support, and advocacy to parents seeking help for their children and administers the DCFHE Parent Consultant Program. In addition, the toll-free Family Health Information Line refers parents who express interest in child development, school readiness, literacy, discipline,

violence prevention, disabilities, special education, transitions, and health-related issues to RIPIN and other appropriate community-based resources. Parent consultants are placed in the following DCFHE programs: Immunization, Birth Defects, PPEP, and Adolescent Transition.

RI Chapter of the March of Dimes (MOD) works with DCFHE and Women and Infants Hospital to reduce prematurity in RI via the RI Task Force on Premature Births. A second imitative places family support in the state's only neonatal specialty care nursery at Women and Infants Hospital and blends the expertise of a Parent Consultant and a MOD parent support professional to provide support to families and staff.

Interagency Coordinating Council on Environmental Lead (ICCEL): The ICCEL, created as a part of the Lead Hazard Mitigation Law passed in June of 2002, and is chaired by the Director of Health, with members that include DHS, the RI Department of Environmental Management (DEM), the Office of the Attorney General, the RI League of Cities and Towns, and the RI Housing Resources Commission. The ICCEL oversees the implementation of the Lead Hazard Mitigation Law and reports to the Governor on an annual basis.

Brain Injury Association of RI maintains a registry of individuals with traumatic brain and spinal cord injuries for the purpose of helping children and adults with TBSCI access appropriate services, including SSI and rehabilitative services. The program corresponds with individuals with TBSCI informing them of the Brain Injury Association of RI. The OSHCN has seen a 500% increase in the reporting with the passage of Rules & Regulations Pertaining to Traumatic Brain and Spinal Cord Injuries in 2007.

DCFHE contracts with the Olneyville Housing Corporation to assess and address built environment barriers and opportunities to healthy living; facilitates a Health Promotion Policy Council to set and move a statewide policy agenda to prevent childhood obesity; through SafeRI-Violence and Injury Prevention Program contracts with Day One, a private non-profit, to teach relationship violence prevention in schools; contracts with RIEAP Student Assistance Services for implementation of youth suicide prevention strategies in schools and communities. The Tobacco Control Program contracts with Quality Partners, Inc. and the RI Health Center Association to provide quit smoking services to eliminate tobacco related disparities among populations, including pregnant women. The NE Regional Chapter of the American Lung Association RI manages the Tobacco Control Network.

RI Chronic Care Collaborative includes 10 health center sites to improve asthma care among pediatric patients using the Care Model and Model of Improvement.

RI Asthma Control Coalition works to reduce asthma hospitalization and emergency department visit rates. The Asthma in Schools and Clinical Care Committees target youth through addressing the environmental health of schools, communication with school nurse teachers and improvement in asthma care among primary care providers.

State Support for Communities

DCFHE supports breastfeeding training of WIC nutritionists, WIC Peer Counselors and community educators, by offering training as Certified Lactation Consultants (CLC) and International Board Certified Lactation Consultants (IBCLC).

Ready to Learn Providence (R2LP) supports the Providence Plan's community-driven strategic planning initiative to increase utilization of MCH services among young families, including CYSHCN living in the city of Providence. R2LP is improving the quality of child care through expanding and better connecting providers to professional development, expanding the capacity and cultural competency of existing early childhood learning programs, and institutionalizing a kindergarten transition initiative designed to better prepare children for learning at school entry. Parents participate in all phases of R2LP activities.

The Office of Minority Health contracts with nine minority serving, community-based organizations to deliver health promotion and disease prevention programming, referral services and consumer empowerment education. The DCFE Health Promotion & Wellness Team contracts with multiple MCH partners working with schools and CBOs to reduce childhood obesity, tobacco use and exposure among pregnant women and children, and suicide among teens and young adults. The DCFHE is working with the Providence Plan to develop a statewide housing database to target unhealthy housing in the core cities.

Child Care Support Network supports healthy child care environments through contracts to local community agencies. These agencies have staff that conduct technical assistance to childcare providers to help them promote children's mental health and healthy development. The project also helps ensure that efforts around the state to promote children's healthy development are coordinated.

Successful Start: The Successful Start Early Childhood Comprehensive Systems initiative engaged in a two-year, statewide planning effort to assess capacity, quality, and integration issues surrounding five core components of the state's existing early childhood system including medical homes, social and emotional development, child care, parenting education, and family support for all children. Progress has been made on all of the goals within the plan and after 3 years of implementation, the plan is being updated. A transition team to include adolescent systems development is in place this year.

The Title X Family Planning Program collaborates with several federally qualified community health centers, Planned Parenthood of Southeastern New England, Youth in Action, and the Women's Division of the Rhode Island Department of Corrections to provide affordable, confidential contraceptive and preventive health services to culturally diverse, primarily low-income men and women.

The Ryan White HIV Care Program partners with two hospital-based ambulatory HIV specialty clinics and three community-based HIV service providers to provide medical care, case management services and support services to persons living with HIV/AIDS (PL WHA) in RI. The program's AIDS Drug Assistance Program (ADAP) partners with the state's entire private pharmacy network, a pharmacy benefits manager (HP Enterprises) and the state's medical care and community-based social services networks to provide HIV medications to PL WHA as a payer of last resort.

Coordination With Health Components Of Community-Based Systems

The Immunization Program provides all recommended childhood vaccines to pediatric providers at no charge through universal purchase and distribution system. The program coordinates with community based hospitals and health centers to offer free vaccines to uninsured children.

The WIC Program is co-located within local Community Health Centers and Hospitals providing direct referrals and increased access to services including medical care, dental care, social services, lead screening and immunizations.

The Perinatal and Early Childhood Team coordinates with a number of existing systems relevant to children's health care. Watch Me Grow RI, the First Connections Home Visiting Program, and the Child Care Support Network all coordinate with SCHIP, Early Intervention, the system of Community Mental Health Centers, and the Child Care Subsidy system. The Newborn Screening program coordinates with the birthing hospitals, the State Laboratory, and the RI Hospital. The Lead Poisoning Prevention Program also coordinates with Medicaid, the states system of Lead Centers and the two lead clinics in the state that provide medical treatment for significantly lead poisoned children.

The DCFHE is currently participating in the several other AAP supported CATCH community initiatives, including the Pawtucket/Central Falls, Newport, Mt Hope neighborhood, Westerly, and Woonsocket supporting pediatricians leadership in community level health efforts including medical homes.

First Connections Home Visiting Program, via HEALTH contracts with, 4 community based agencies conduct home visits to almost 25% of families with newborns who have specific risk profiles created from information collected at birthing hospitals providing general parenting information, conduct home assessments, and educate parents about infant care, and link families to appropriate resources. Other community partners (i.e., pediatricians / Early Intervention) can also make referrals to the program for specific concerns in which case the program will make home visits to children who are beyond the newborn period and link these families with services. Home visitors also serve as the follow-up staff for the Newborn Screening, Lead Poisoning Prevention, and Immunization Programs. First Connections is an active contributor to the Child Find system for the Early Intervention program. The DCFHE is implementing an intensive home visiting model as well as prenatal home visiting through First Connections.

Watch Me Grow RI is a program that provides support to pediatric primary care providers and child care providers to implement developmental screening within community-based settings. WMGRI also provides technical assistance around understanding community services and how to refer/link to these services. As a result of the AAP recommendation around autism specific screening in addition to standardized developmental screening, WMGRI and the OSHCN provides technical assistance on standardized measures of development.

The DCFHE convened a Healthy Housing Collaborative, a statewide collaborative of agencies and individuals, designed to initiate genuine partnerships to help move communities towards a more comprehensive approach to healthy housing practices and works to engage and encourage landlords to use the web based HomeLocatorRI.net to promote their rental units with healthy housing characteristics for families in need. A partnership between RI KidsCount, the Annie E. Casey Foundation and DFCHE helped launch the first ‘health and house' indicator in the 2009 edition of the KidsCount Factbook.

Coordination of Health Services with Other Services at the Community Level

During a WIC Certification appointment clients are assessed for any needs of clients on an individual basis. Appropriate referrals are made (i.e. smoking cessation, housing, fuel assistance, food pantries, etc).

First Connections Home Visiting Program coordinates with the system of pediatric primary care to accept referrals, coordinate information exchange and make referrals to many diverse community programs.

The Newborn Screening Program coordinates with community based and hospital based programs, which address the needs of families with children who have specific disabilities and disorders. The Newborn Screening Program provides universal newborn screening and follow-up for 29 metabolic, endocrine, and blood disorders. The program also provides hearing screening and developmental risk assessments for newborns. Implementation of a newborn developmental risk module, integrated with a new electronic birth certificate system.

OSHCN and parent consultants worked with parents to develop "medical passports" which contain information about services for CYSHCN and their families in RI. The DCFHE works with the New England Regional Genetics Group (NERGG) for technical assistance in implementing HEALTH's statewide genetics plan focusing on access to genetics services.

The Birth Defects Program is working to ensure that children with birth defects have a medical home and that families have access to preventive services. The DCFHE has worked closely with

its Birth Defects Advisory Council to design and pilot a checklist of services for specific conditions for families and health care providers.
A parent consultant works with the Advisory Committee to develop/implement statewide birth defects prevention strategies. The Birth Defects Program works with PPEP and the RI Parent Information Network to obtain service and referral information for children with birth defects. The Birth Defects Program also worked closely with hospitals and clinics to enhance and expand case ascertainment and planned the 2nd annual Birth Defects Grand Rounds and Forum on fetal alcohol syndrome.

The Minority Health Promotion Centers are located in nine community agencies including one health center, one mental health center, two voluntary agencies, one housing authority, one community development corporation, one YWCA, and two minority assistance agencies.

The Childhood Lead Poisoning Program refers children who are significantly lead poisoned to a network of lead centers that deliver direct services in the form of non-medical case management and provide family support and referrals. The DCFHE recently lowered the blood lead level used to determine eligibility for referral in an effort to promote primary prevention of lead poisoning and has a Memorandum of Understanding with lead centers to send referrals and work collaboratively in the monitoring, evaluation, and quality assurance of the case management of lead poisoned children. DCFHE also provides lead center referrals for children with elevated blood lead levels below the current CDC level of concern; lead centers are funded through an agreement with a lead paint company. DCFHE supports a clinic offering lead screening testing free of charge for children who are uninsured in one of the major pediatric hospitals in Providence.

The Tobacco Control Program offers the Quit Works Program to health care providers to provide their clients with a proven quit smoking resource and Nicotine Replacement Therapy.

The Initiative for a Healthy Weight provides tools and training to pediatric providers to address childhood obesity.

C. Organizational Structure

The Division of Community Family Health and Equity (DCFHE) in the RI Department of Health (HEALTH) is responsible for the administration of programs related to title V Maternal and Child Health Block Grant. HEALTH is located within the Executive Office of Health and Human Services EOHHS), a cabinet agency that directly reports to the Governor. EOHHS is comprised of the Department of Children, Youth and Families; the Department of Elderly Affairs; the Department of Human Services; Department of Mental Health, Retardation and Hospitals and HEALTH.

The DCFHE is organized into the Office of the Executive Director and 6 Teams as follows:

The Office of the Executive Director focuses on overall division cross-cutting public health resources, administration and coordination of division activities and includes:

The Operations Team manages and monitors CFHE resources and investments.

The Program Administrator is responsible for analyzing national and state policy to assess potential impacts, and recommend positions, responses, resource allocation and strategies to enhance integration.

Chronic Care and Disease Management Team includes:

Diabetes Prevention and Control Program addresses the burden of diabetes in the state by

targeting controlling diabetes and preventing diabetes-related complications.

Heart Disease and Stroke Prevention Program builds and maintains an infrastructure to sustain a diverse partnership to plan and implement systems change to improve cardiovascular heath status and to eliminate disparities in heart disease and stroke burden in the state.

Asthma Control Program addresses the prevalence and burden of asthma among people of all ages living in Rhode Island and focuses on quality clinical asthma care, quality asthma patient education, and environmental health to address patients' ability to control their asthma.

Colorectal Cancer Screening Program improves colorectal cancer screening rates among all Rhode Islanders aged 50 and older, African American Rhode Islander's aged 40 and older and ensure access to screening among underserved populations.

Comprehensive Cancer Control (CCC) works to eliminate health disparities in cancer services and programs in Rhode Island and create a workforce knowledgeable in cancer in underserved communities.

Women's Cancer Screening Program provides breast and cervical screening, diagnostic services, and treatment for women ages 40-64, quality assurance, technical assistance to providers on women's cancer screening issues, public education & outreach to increase the number of women screened in the target groups.

Arthritis Program works to raise awareness about arthritis is Rhode Island.

Health Disparities and Access to Care Team includes:

Office of Minority Health (OMH) works to eliminate racial and ethnic health disparities and assure that racial and ethnic minority populations have equal access to high quality health services. Activities focus on health system enhancements and programming related to disease prevention, health promotion, service delivery, and monitoring the health status of racial and ethnic minority populations. Leads HEALTH's Healthy RI 2010 and implementation of the federal Culturally and Linguistically Appropriate Services (CLAS) mandates. The Refugee Health Program works to ensure that refugees and asylees enter into a comprehensive system of care.

Office of Women's Health works to eliminate health status disparities for Rhode Island women by promoting a gender-informed, coordinated, comprehensive, prevention focused approach to women's health across the lifespan.

Office of Special Health Care Needs ensures family-centered, community based, systems of care for Rhode Islanders with special healthcare needs through infrastructure building, training / technical assistance, and collaboration with families, other state agencies, health plans, and community agencies and linkages other state agencies such as the Department of Education, the Department of Human Services, Department of Elderly Affairs, Department of Mental Health and Retardation, and Department of Children, Youth, and Families to serve people with disabilities in their care.

Disability and Health Program promotes health and wellness for people with disabilities and prevents secondary health conditions and maintains the Traumatic Brain Injury database, and assures successful transition of adolescents with disabilities to the adult health care system.

Pediatric Specialty Services provides an integrated system of care for children with special healthcare needs and maintains quality assurance in this system through educating, supporting and empowering families raising children with special healthcare needs.

Office of Primary Care and Rural Health (OPCRH) focuses on increasing access to high-quality,

comprehensive, coordinated, culturally appropriate care for underserved Rhode Islanders through needs assessment, promotion of the health care safety net, workforce development, collaboration with health system stakeholders, and community capacity-building. Similarly, the State Office of Rural Health strengthens rural/non-metro health care delivery systems.

Healthy Communities reduces health disparities and improve access to care by providing communities with the information, skills, and resources they need to improve preventive health systems. Healthy Communities strives to create more effective connections between local initiatives and statewide policy development.

Hospital Charity Care monitors fidelity to State regulations that codify the long-standing tradition of non-profit hospitals providing free or discounted care to the uninsured poor.

Health Promotion & Wellness Team includes:

Tobacco Control Program prevents the initiation of tobacco use among young people, eliminating nonsmokers' exposure to secondhand smoke, promoting quitting among adults and young people, and identifying and eliminating tobacco-related disparities.

Initiative for a Healthy Weight (IHW) changes social, political and physical environments to make the healthy choice the easy choice for all by developing an annual policy agenda and building a strong network of advocates; improving community walk-ability; safety; access to recreation; access to healthy foods; point of purchase caloric information in restaurants; and strengthening nutrition guidelines for childcare providers.

Safe RI / Violence and Injury Prevention Program provides communities and policymakers with data and technical assistance needed to implement effective injury prevention programs and policies.

Healthy Homes and Environment Team includes:

Childhood Lead Poisoning Prevention and Healthy Homes works to eliminate childhood lead poisoning in Rhode Island's youngest children, and to reduce other environmental threats in the home.

Environmental Health Risk Assessment identifies and assesses environmental risks to public health.

Environmental Lead works to protect the public, specifically children under the age of six, from lead in the environment by conducting comprehensive lead inspections and providing technical assistance to owners to ensure all lead hazards are abated.

Indoor Air Quality protects Rhode Islanders from unnecessary exposures to airborne asbestos fibers and radon, and works with schools and building owners on issues relating to indoor air quality.

Occupational Consultation conducts health and safety evaluations at Rhode Island workplaces and provides technical assistance and follow-up training to ensure that hazards are addressed.

Perinatal and Early Childhood Health (PECH) Team includes:

Early Childhood Health develops an effective early childhood system to address the needs of all children, while providing more intensive services for infants and children most at risk including:.

Newborn Screening Program is a multi-focused screening program for newborn infants comprised of Newborn Metabolic and Genetic Screening, The Rhode Island Hearing

Assessment, and Newborn Developmental Risk Screening.

First Connections Home Visiting is the state's home visiting program for pregnant women and families with young children who are at risk for poor developmental outcomes.

The Child Care Support Network provides Health and Mental Health Consultation services to child care providers, children and families in community settings.

Watch Me Grow RI provides technical assistance to implement a developmental screening for children birth to three in pediatric primary care offices and childcare settings.

Successful Start facilitates the implementation of recommendations for system improvements relevant to early childhood services and programs.

RI LAUNCH is an initiative that addresses overall children's health in pediatric primary care offices and child care settings: facilitating the implementation of child wellness screens and follow-up to behavioral health issues.

The Special Supplemental Nutrition Program for Women, Infants and Children (WIC) provides supplemental foods, nutrition education and information, referral and coordination of services to women and children who are at nutritional risk and acts as adjunct to good health care during critical periods of growth and development to prevent the occurrence of health problems and improve health status. It includes the Farmer's Market Nutrition Program that enables WIC clients to purchase locally grown fresh fruits and vegetables at farmer's markets.

WIC Breastfeeding Support and Promotion includes

Breastfeeding Peer Counselor Mother to Mother Program to promote and support breastfeeding to WIC participants.

The Tender Lactation Care (TLC) Program provides post-partum breastfeeding assistance to WIC mothers who deliver at Women and Infants Hospital. Notes are sent to the local WIC Programs for appropriate follow-up breastfeeding education and support.

Adolescent Health develops initiatives at the State and community level to build a comprehensive system of care for youth.

Adolescent Medical Home provides technical assistance and tools on adolescent medical home, identifies additional communities to pilot the model and seeks additional support to promote the medical home model statewide.

Healthy Teen Project is a neighborhood driven pilot project to develop a comprehensive assets based approach to prevent unhealthy adolescent risk taking behaviors and their consequences, and promote resiliency and positive health habits in adolescents and their families.

RI Teenage Pregnancy Prevention-promotes evidence based local approaches to teenage pregnancy prevention statewide.

Thrive, a partnership with the RI Department of Education to build an infrastructure for coordinated school health programs to integrate school health into the state education reform agenda.

Youth Action Research designed to increase youth participation and voice in public health efforts.

Mental Behavioral Health Resource Center includes partnerships to address mental behavioral health needs of students in schools and communities

Preventive Services and Community Practices Team includes:

Office of Immunization works to prevent and control vaccine preventable disease in Rhode Island by increasing the number of fully immunized residents thru vaccine distribution, quality assurance, public and provider education, information dissemination, surveillance and community collaboration.

The Childhood Immunization Program serves children birth-18 years of age thru universal vaccine purchase and distribution for all children, quality improvement, and an integrated program/practice management information system and supports initiatives for special populations, such as Vaccinate Before You Graduate and Perinatal Hepatitis Prevention

The Adult Immunization Program manages the purchasing and distribution of influenza vaccine to providers for all adults aged 19 and older and supports initiatives for uninsured adults.

Oral Health Program seeks to improve the oral health of Rhode Islanders by: providing oral health/public health leadership developing, implementing, and evaluating state plans/prevention programs; and collaborating with partners to build and sustain community capacity.

The Office of HIV/AIDS & Viral Hepatitis is composed of five major areas including surveillance, viral hepatitis, HIV prevention, HIV Provision of Care and Minority Initiatives.

Reproductive Health promotes the reproductive health of youth and adults and provides individuals with the information and means to exercise personal choice in determining the number and spacing of their children.

Title X Family Planning Program provides access to comprehensive family planning and preventive services.

Women's Health Screening and Referral Program provides no-cost pregnancy tests, and a risk assessment to all women requesting services at Title X clinics.

D. Other MCH Capacity

There are 105 Full-Time Equivalents (FTEs) who work in the DCFHE as state employees. This number includes staff that provides planning, implementation, evaluation, and data analysis. In addition, the Division's staffing configuration includes 12 consultants, 14 ADIL consultants and five parent consultants. DCFHE is hiring 12 time-limited FTEs as part of its CDC ARRA CPPW physical activity, nutrition, and tobacco prevention programs and one part-time limited FTE for CDC-ARRA Chronic Disease Living Well program. There is also two WIC ADIL staff through USDA ARRA funds.

Parent consultants are culturally diverse and are assigned to DCFHE programs based on the program's need for parent participation and the parent consultant's experience with the program. Parent consultants are assigned to the WIC Program, the Immunization Program, the Birth Defects Program, and the OSHCN. Many of the parent consultants are parents of CYSHCN and all are consumers of DCFHE programs or have been in the last three years. Parent consultants

are full partners in policymaking, outreach, and program quality assurance and evaluation.

In addition to these parent consultants, the DCFHE also manages the Pediatric Practice Enhancement Project (PPEP), has placed 24 parent consultants in pediatric practices serving high volumes of CYSHCN throughout the state. There are 12 pediatric primary sites, 10 specialty care sties and 2 sites outside the medical community. The pediatric primary care sites include hospital-based primary care clinics, health centers, private physician offices, and private physician group practice in geographic location throughout the state serving ethnically, culturally, linguistically, and geographically diverse populations. Specialty care sites include multi-disciplinary evaluation, intensive clinical, disability specific, special intervention and dental. The additional 2 non-medical sites includes a correction department and social service agency.

All DCFHE staff, with the exception of PPEP parent consultants, are centrally located at the RI Department of Health in Providence, RI. Brief biographies of senior level management staff are included below.

Executive Director's Office
Ana Novais, MA, is the Executive Director of the Division of Community, Family Health and Equity and provides leadership for the Division and its programming. Ms. Novais provides leadership and planning to eliminate health disparities, assure healthy child development, to reduce/prevent/control chronic disease and disabilities, as well as HIV/AIDS and Viral Hepatitis, and how the built environment affects health.

Ms. Novais also provides leadership for the Division's efforts related to maternal and child health and its programming. She is active the leadership of the Association of Maternal &Child Health Programs (AMCHP), the National Academy of State House Policy, and numerous other organizations. Ms. Novais recent interests include use of public health information for leadership and consumer decisions, integrated local family health and development programs for young families, populations tracking systems for children, and training of professionals for comprehensive primary care, especially in a managed care environment.

Peter Simon, MD, MPH is the DCFHE Deputy Director. He is responsible for establishing medical policy for all DCFHE programs. In addition, he provides technical assistance on areas of prevention services for women, infants, children, and adolescents to other divisions within HEALTH (i.e. sexually transmitted diseases, laboratory screening for inborn errors of metabolism and hemoglobinapathies, school health, injury control) and to other state agencies.

Carol Hall-Walker, is Chief Program Administrator, is responsible for strategic planning related to maternal and child health, management oversight of the six teams to enhance and expand integration that include the programs directly receiving Title V support, communications and public engagement in partnership with DCFHE programs. Ms. Hall Walker also manages the Preventive Health and Health Services Block Grant. She also provides policy, administrative and management support to the Executive Director. Her activities include helping to set direction and Title V resources allocation to meet DCFHE priorities.

Perinatal & Early Childhood Health Team

The Perinatal & Early Childhood Health Team is lead by Blythe Berger, ScD. This team includes the Newborn Screening and Follow-up Programs, Child Care Programs, the WIC Program, and Adolescent Health.

The Office of Early Childhood includes Successful Start Early Childhood Systems initiative, the Newborn Screening Program, the Family Outreach Program, the Child Care Support Network and the "Watch Me Grow" Program.

Ann Barone, LDN is the Chief of the Office of WIC. In this capacity, Ms. Barone is responsible for

the overall administration of the WIC Program, which includes nutrition education, farmers market, and breastfeeding promotion and support, and outreach, food delivery, financial management, and management information systems.

Rosemary Reilly-Chammat, EdD is the State Adolescent Health Coordinator and manages the Adolescent Health Program including adolescent medical home efforts, teenage pregnancy prevention initiatives, thrive partnership with the RI Department of Education, an endeavor to develop prevention focused mental health capacity in schools and healthy youth development community based efforts in core city neighborhoods.

Krisitne Campagna, MEd. is responsible for Newborn and Early Childhood Screening and Follow-up programs and for ensuring that all newborns in RI receive a developmental, metabolic and hearing screen and appropriate follow-up. In addition, Ms. Campagna works with community programs to support developmental screening and follow-up in early childhood.

Chronic Care & Disease Management Team

Under the direction of Dona Goldman, RM, MPH, this Team is responsible for the Diabetes Prevention and Control Program, Asthma Control Program, Heart Disease and Stroke Prevention Program, Women's Cancer Screening Program, Comprehensive Cancer Control Program and Colorectal Screening.

Health Disparities & Access to Care Team

Carrie Bridges, MPH, is the team lead for this unit and responsible for the management and administration of the Office of Minority Health, Office of Special Health Care Needs, Office of Primary Care and Rural Health and the Office of Women's Health.

Deborah Garneau, MA is the Chief of the Office of Special Health Care Needs. In this capacity, Ms. Garneau is responsible for the management and administration of the Disability & Health Program, the Pediatric Practice Enhancement Project (PPEP), and Pediatric Specialty Services.

Health Promotion & Wellness Team

Jan Shedd, EdM, is the Team Lead of the Health Promotion & Wellness Team. In this capacity, Ms. Shedd is responsible for the management and administration of the Tobacco Control Program, the Initiative for Healthy Weight, and the Safe RI / Violence and Injury Prevention Program. The Team changes social, political, and physical environments to support healthy living through the life course, and is committed to achieving health equity for all Rhode Islanders. The Team is currently coordinating a small city CDC ARRA Communities Putting Prevention to Work Tobacco Control and Prevention Project with the City of Providence. It also has ARRA CPPW funds for a statewide obesity prevention initiative.

Seema Dixit, MS is the Program Manger for the Tobacco Control Program and serves as Deputy Team Lead. The program seeks to prevent initiation of tobacco use among young people, eliminate nonsmokers' exposure to secondhand smoke, and promote quitting among adults and young people, with focus on identifying and eliminating tobacco-related disparities.

Eliza Lawson is Program Manager for the Initiative for Healthy Weight, with a particular focus on childhood obesity prevention, and building state and local infrastructure to collect data, and increase physical activity and consumption of healthy foods.

Beatriz Perez is the Program Manger for the SafeRI, Violence and Injury Prevention Program, which has prioritized decreases in falls and injuries among older adults, preventing death and disability related to motor vehicle crashes, prevention of youth suicide, and prevention of sexual violence.

Preventive Services and Community Practices Team

Patricia Raymond, RN, MPH is the team lead for this unit and oversees the management and administration of the Office of Immunization, the Office of HIV/AIDS & Viral Hepatitis, Reproductive Health and the Oral Health Program.

Laurie Leonard is the Program Manager for the Oral Health Program, which focuses on the oral health of disparate and vulnerable populations, including children in at risk populations. To increase the oral health of this group, the staff within the Oral Health Program includes a RI Dental Sealant Coordinator (James Hosmer, DMD), who works with the school-based dental sealant programs in RI.

Healthy Homes and Environment Team

Under the direction of Robert Vanderslice, PhD, this Team is responsible for the Healthy Housing and Communities Program and the OSHA Consultation Program. Magaly Angeloni, MBA, is the manager of the Healthy Homes and Communities Program that includes lead poisoning prevention. The Healthy Homes and Environment team protects the health and safety of children, workers, and the general public by identifying and decreasing environmental hazards

Center for Health Data and Analysis

Sam Viner-Brown, MS, has been selected to lead the Department's Center for Health Data and Analysis. In this capacity, Ms. Viner-Brown is responsible for developing, supporting, collecting, and analyzing data for needs assessment, policy development, program management, quality improvement, epidemiological, and reporting purposes in collaboration with national, state, and local partners.

Ellen Amore, MS serves as program manager of KIDSNET, a fully operational statewide data exchange The KIDSNET data base aggregates a variety of preventive services for children born after January 1, 1997.

E. State Agency Coordination

Affecting positive change in maternal, child, and family health requires a common vision and collective effort. The DCFHE enjoys strong working relationships with other state departments and community-based agencies and organizations that enhance it efforts to promote and protect the health of MCH populations. The DCFHE ensures that resources are coordinated and maximized through integrated program planning conducted by senior staff

State Agency Partnerships

There are five other state agencies that provide various services to the state's MCH populations, including CSHCN. These five agencies include the RI Department of Human Services (DHS), RI Department of Mental Health, Retardation & Hospitals (MHRH), RI Department of Children, Youth & Families (DCYF), RI Department of Corrections (DOC), and RI Department of Education (RIDE).

The DCFHE has a number of formal interagency agreements with DHS related to Medicaid. including Early Periodic Screening, Diagnosis & Treatment (EPSDT) with specific recommendations for standardized developmental screening, autism screening, adolescent transition planning, influenza vaccine for adults and non-medical case management services for persons living with AIDS. Currently the DCFHE is working with DHS to enter into another agreement to secure Costs Not Otherwised Matched by Medicaid funding for AIDS Drug

Assistance Program medications for uninsured persons living with HIV/AIDS. KIDSNET Program has a data sharing agreement in place with DHS to ensure that all children receive appropriate preventive care, follow-up and services to promote healthy child development.

The DCFHE, in partnership with DHS, DCYF and community providers, supported a model of developmental services designed to increase the numbers of young children receiving comprehensive screening for a range of developmental and behavioral problems and referral to appropriate intervention and treatment services.
DCFHE staff works closely with DHS to create a statewide infrastructure for addressing childhood lead poisoning among Medicaid-eligible children with four regional Certified Lead Centers, providing comprehensive case management services and coordinated linkage to other services and supports. DHS also partially funds the Child Care Support Network (CCSN), which provides health and mental health consultation to child care providers and children in child care. The DCFHE sends monthly reports of newborns with Medicaid covered deliveries to Medicaid to facilitate prompt enrollment in RIte Care.

DCFHE staff works closely with DHS on implementing the state's care coordination system for CSHCN (CEDARR), the state's parent consultant program, and the Family Voices Leadership Team (which is dedicated to removing system barriers to CSHCN and their families). DCFHE staff also participates with the DHS Office of Child Support Services on the RI Fatherhood Coalition. DCFHE staff coordinates with the DHS Kids Connect program which provides additional staffing so that children with special health care needs can participate in child care with typically developing peers.
DCFHE staff participated in the development of the Global Consumer Choice Compact 1115 Waiver Demonstration that was submitted to CMS in August 2008 and approved January 2009. DCFHE staff continues to participate on Waiver Implementation Workgroups as it relates to ensuring a medical home and access to screening and treatment to Medicaid recipients.
The DCFHE works with RIDE to ensure an integrated educational system that serves CSHCN transitioning to adulthood. The DCFHE is working with RIDE and the RI School for the Deaf to coordinate and maintain follow-up for infants identified with hearing loss. DCFHE works with RIDE on a broad range of health issues as it relates to academic achievement. DCFHE and CHDA develop joint publications with RIDE on links between health and academic success. HEALTH participated with RIDE in the development of a new survey for students, teachers and parents related to factors concerning teaching and learning including health issues. DCFHE also, works closely with RIDE to address mental health supports, tobacco control, violence prevention, teen pregnancy prevention and overweight/obesity prevention in school settings including the creation of an integrated data system. RIDE maintains the website, for RI's coordinated school health program, thrive including contacts and resources to support coordinated school health efforts at RIDE and HEALTH. RIDE partners with KIDSNET to mail child outreach screening information to families of children turning three years old.

The DCFHE partners with DCYF on the implementation of the new Child Abuse Prevention and Treatment Act regulations pertaining to young children who have been victims of abuse/neglect. DCYF employs a First Connections home visitor to facilitate access to Early Intervention services for children under the age of three. DCYF and KIDSNET exchange data to help assure children in DCYF care receive appropriate preventive services and to direct communication to the legal guardians.
The Immunization Program (IP) established a partnership with DCYF to ensure that children in child care and preschool settings are up-to-date on their immunizations. The IP's parent consultant conducts quarterly immunization education trainings for DCYF workers as well as in-home daycare workers to educate staff about the immunization requirements for entry into daycare and preschool.

The DCFHE also has works with the RI Department of Environmental Management (DEM) to assure that public complaints about illegal exterior lead-based paint removal are addressed. The DEM assists the WIC Program in operating the Farmers Market Nutrition Program by serving as a

liaison to farmers and organized farmers' markets to ensure that sales of locally grown produce to program participants are in compliance with rules and regulations as well as coordination of training.

The DCFHE has a Cooperative Agreement with the Department of Transportation to implement a Safe & Active Commuting Program to develop a sustainable state infrastructure to support active transportation for children and adults and make policy, program and environmental changes that promote safe walking and biking. The project purchases and distributes bicycle helmets to children.

The DCFHE continues to partner with the Housing Resources Commission under an MOU to identify effective environmental health interventions at a statewide level across housing and health programs in the state. The partnership benefits families by coordinating efforts to provide healthy, safe, and affordable housing to all Rhode Islanders.

Legislative Initiatives

DCFHE staff participate on the Governor's Council on Mental Health, the Permanent Legislative Commission on Child Care, Governor's Commission on Disabilities and the RI Transition Council (for youth with disabilities transitioning to adulthood). DCFHE staff participated on shorter-term legislative initiatives, including Early Intervention, vision screening, childhood lead poisoning, tobacco control, injury prevention, and childhood obesity.

Coordination with Other HEALTH Programs

With respect to internal collaboration, the DCFHE works closely with other HEALTH programs on an ongoing basis. The Title V-funded programs in DCFHE work closely with other division and department programs on an ongoing basis This has enabled better collaboration around oral health, medical home, teenage pregnancy prevention, obesity prevention, tobacco control, injury and youth suicide prevention, STD prevention, and control and chronic disease and environmental issues. The DCFHE works closely with the Center for Health Data and Analysis (CHDA), including KIDSNET, to support maternal and child health data needs. An Interdepartmental Surveillance and Statistics Group facilitates data /information/best practices sharing within HEALTH.

The DCFHE has begun a Project Management Initiative (PMI) to fully integrate Department-wide operations, equity agenda and policy efforts across a number of high priority areas. The Initiative for a Healthy Weight is providing lead staff for a Childhood Obesity PMI, which will increase the impact and leverage resources to advance childhood obesity efforts. The Health Promotion & Wellness Team is working with the Chronic Care and Disease Management Team to bring individual and family wellness strategies to small businesses. The lead poisoning program collaborates with the asthma program and is assessing the feasibility of training lead center staff to incorporates asthma education and other healthy homes initiatives when visiting the homes of children with elevated blood lead levels. The Immunization Program collaborates with the Viral Hepatitis Program working to provide necessary vaccinations for at-risk adolescents and adults. The Office of Minority Health has organized training for DCFHE staff on culturally competency and the provision of linguistically accessible services. The Maternal and Child Health Block Grant is a PMI, to help create integration and synergy within HEALTH for maternal and child health efforts.

The DCFHE also participates as a member of the Department's Center for Public Health Communication, which sets policy and procedures for strategic and effective communication. The DCFHE's Initiative for a Healthy Weight is working closely with KIDSNET staff and the Director's office on a childhood height and weight electronic data collection project with surveillance and coordination of care applications.

KIDSNET made immunization information available to the Division of Infectious Disease and Epidemiology for disease outbreak investigations. The DCFHE also has ongoing partnerships with HEALTH's Division of Environmental and Health Service Regulation, which provides comprehensive site reviews of licensed health care facilities, including hospitals and community-

based health centers. In addition, the DCFHE works closely with the Office of Vital Records to coordinate data collection at maternity hospitals and to integrate birth certificate data with KIDSNET and newborn screening systems. KIDSNET works with the Refugee Health Program to help track immunization and lead screening in refugee children.

The DCFHE participates on the state's Child Death Review Team, coordinated by HEALTH's Medical Examiner's Office. HEALTH's Division of Laboratories works with the Lead Program to analyze lead screening specimens and collect data. The Lead Program coordinates efforts with HEALTH's Refugee Health Program to ensure that refugees are screened for lead. In addition to regular coordination around programmatic data management, KIDSNET holds quarterly stakeholder meetings that include representatives from all HEALTH programs participating in KIDSNET.

Collaboration with Private Organizations & Associations

The Division's partnerships with private, community-based organizations and associations are extensive. The following represents a summary of several of its major relationships.

Private Provider Community: The Medical Director is active in professional provider organizations. DCFHE staff has worked closely with the RI Chapter of the American Academy of Pediatrics (RIAAP), the RI Chapter of Family Practitioners, and the RI Chapter of the American Academy of Obstetricians and Gynecologists on a number of DCFHE initiatives, including the Women's Health Screening & Referral Program (WHSRP), KIDSNET, RI LAUNCH, and Watch Me Grow RI. DCFHE works closely with the Physicians' Committee for Breastfeeding in RI. All primary care providers use KIDSNET. DCFHE staff provides technical assistance to Rhode Island CATCH projects funded by the AAP including an adolescent medical home project in Woonsocket and an effort to increase in prenatal care in the first trimester project in Washington County. RI maintains a universal vaccine policy and provides vaccine to all providers at no cost.
Community Health Centers: A significant proportion of DCFHE investments support activities in community health centers including, WIC, Family Planning, PPEP Parent Consultants, WHSRP, Tobacco Cessation Watch Me Grow, and two SBHCs. The DCFHE works directly with individual community health centers and the RI Health Center Association on larger policy issues impacting community health services delivery.

Hospitals: The DCFHE has strong partnerships with several hospitals in RI. DCFHE provides funding to the Children's Neurodevelopment Center (CNDC) at Hasbro Children's Hospital. Memorial Hospital is a Title X family planning site. The Newborn Screening Program works closely with Women & Infants' Hospital and other birthing hospitals in RI around training and quality assurance. The Newborn Screening Program also works closely with metabolic, cystic fibrosis, and hemoglobinopathy clinics at Rhode Island Hospital for diagnosis, treatment, and follow-up. Newport Hospital is collaborating with the DCFHE and other partners on the Newport County Healthy Communities initiative. The DCFHE supports lead and immunization clinics for uninsured children at Rhode Island Hospital and St. Joseph Hospital. The Birth Defects Program has been working closely with Women & Infants', Kent County, and Hasbro Children's Hospital to improve case ascertainment. Representatives from these hospitals provide information, consultation, and guidance; several are members of the Birth Defects Advisory Council. The Immunization program provides all birthing hospitals in the state with a supply of Hepatitis B vaccine so that newborns receive the birth dose prior to discharge and the vaccination is reported to KIDSNET. PPEP Parent Consultants were placed at Hasbro Children's Hospital, Butler Hospital, Memorial Hospital, and Women & Infants' Hospital. The DCFHE works with Bradley Hospital (the state's psychiatric hospital for children and adolescents) on a mental health resource guide and developing mid-level mental health services for children graduating from intensive programs and to develop school capacity to address mental health concerns.
Insurers: DCFHE, with the largest Medicaid insurer in the state, evaluated the PPEP Parent Consultant Program. The utilization analysis that was presented to all RI health plans demonstrated that CSHCN who received PPEP services had lower health care costs as they had higher utilization of community based services and lower institutional level of care services. The

DCFHE continues to work with the three Managed Care Medicaid organizations in RI to share data and increase support for public health efforts for the vulnerable Medicaid population.
Visiting Nurse Associations (VNAs): The DCFHE has strong partnerships with several VNAs through the First Connections Home Visitors providing home assessments, connection to community services, and help with child development and parenting for almost one-third of all families with newborns each year. First Connections collects housing related information during the initial home visit and the DFCHE will use this data to promote access and availability to healthy housing. In addition, one VNA is a Title X family planning site. Another VNA provides newborn developmental risk assessment statewide, newborn blood spot screening follow-up and hepatitis B follow-up through contracts with the DCFHE. VNAs also participate on the Birth Defects Advisory Council. The VNA provides case management services for pregnant women/new mothers who are infected with chronic hepatitis B and C and the infant to assure completion of vaccination and medical referral.

Child Care Providers: The Child Care Support Network (CCSN) works closely with the child care provider community and families. CCSN is made up of a team of professionals who work with licensed center-based and home-based child care providers to improve the quality of care for all children in the following areas: health and safety, nutrition, curriculum development, early literacy, CSHCN, child development, family involvement, and mental/behavioral health.

Healthy Mothers/Healthy Babies Coalition: The DCFHE participates in this statewide coalition dedicated to improving birth outcomes.
Rhode Island Kids Count: This children's policy organization provides information on child wellbeing and stimulates state dialogue on children's issues. Each year, the agency publishes a factbook, which provides detailed community-by-community pictures of the condition of children in RI. The DCFHE provides a significant proportion of data utilized in the factbook.
Covering Kids Rhode Island: Funded by a Robert Wood Johnson grant, increases children's access to Medicaid by helping local communities develop and implement strategies to enroll potentially eligible children and their families into Medicaid (including RIte Care/RIte Share). The DCFHE works closely with Covering Kids on community systems development initiatives.
Childhood Lead Action Project: This non-profit agency is the only advocacy agency in RI solely dedicated to addressing the problem of childhood lead poisoning. The agency is a member of the Healthy Housing Collaborative.
Rhode Island Public Health Association (RIPHA) is the state affiliate of the American Public Health Association, DCFHE staff participate on the board and other efforts.

Rhode Island Public Health Institute (RIPHI): The RIPHI was formed to organize and activate private sector professionals interested in the advancement of public health in RI. DCFHE personnel participate on the board and other efforts.
Kids First is a non-profit organization that convenes the RI Healthy Schools Coalition and guides communities and their schools to improve the nutritional and physical well-being of children. DCFHE contracts with Kids First to work with school district health and wellness subcommittees. DCFHE staff participate on the steering committee and related workgroups.
Youth In Action (YIA): The DCFHE is partnering with the youth-led, community-based organization YIA to provide family planning outreach, education, and referral services to culturally diverse young men living in the Southside of Providence.
Rhode Island Breastfeeding Coalition (RIBC): RIBC is a coalition of community organizations and groups dedicated to supporting and promoting breastfeeding in RI. Members include lactation consultants from local birthing hospitals, physicians, and other health care professionals. The RIBC organizes statewide breastfeeding events such as "World Breastfeeding Month".

Rhode Island Food Dealers Association: This professional association acts as the liaison between the WIC Program and WIC vendors throughout the state.
Childhood Immunization Action Coalition: The coalition consists of DCFHE staff, community-based agencies, civic organizations, medical care providers, schools, Head Starts, hospitals, and health insurance plans. The purpose of the coalition is to share strategies and develop plans for

improving utilization rates.

Rhode Island Certified School Nurse Teachers' Association: The DCFHE partners with this group to provide input and feedback for the annual school nurse teachers' conference. This conference is an educational opportunity for school nurses from all public and private schools.

Family Leadership & Support Programs: The DCFHE actively collaborates with a number of family leadership and parent support agencies and programs. The DCFHE works closely with leadership from the RI Family Voices and participates in the Family Voices Leadership team. The DCFHE also contracts with the RI Parent Information Network (RIPIN) to provide training and technical assistance to the Parent Consultant Program and the Parent support Network.

Higher Education: HEALTH and the DCFHE have active relationships with many of the state's colleges and universities. HEALTH is working to develop formal agreements with area institutions of higher education to facilitate HEALTH staff training and collaborative research and grant writing. In partnership with 3 Rhode Island Colleges, the Lead Program offers training to nursing students about environmental threats in the home. The DCFHE is also working with the RI Area Health Education Center (housed at Brown University) to develop and offer multidisciplinary training on early childhood mental health. Through the Joint Legislative Commission on the Educating Children with Autism Spectrum Disorders, the DCFHE is designing a teacher competency certification in ASD and incorporating these competencies into undergraduate special education curriculum. The DCFHE partners with Brown University faculty on a variety of special needs, especially Autism and other developmental disabilities.

Ocean State Adult Immunization Coalition -- HEALTH entered into a formal contract with OSAIC to provide support and consultation in regards to adult immunization services.
RI Association of School Principals HEALTH is collaborating with the association on professional development and toolkit related to supporting mental health promotion among school age children.
Coordination with Other Federal Grant Programs

DCFHE programs receive funding from several federal grant programs. These programs include: Family Planning (Title X), WIC (USDA), Newborn Hearing Screening (CDC), RI LAUNCH (SAMSHA), PRAMS (CDC), Immunization (CDC), Lead Program (CDC), Disability & Health (CDC), Tobacco Control Program (CDC), Initiative for Healthy Weight (CDC), SafeRI, Violence and Injury Prevention Program (CDC and SAMHSA), and Child Care Support Network (ACF). DCFHE programming is also supported through several HRSA grants including: Universal Newborn Hearing Screening, President's New Freedom Initiative Integrated Community Systems for CSHCN, State Early Childhood Comprehensive Systems, and Healthy Tomorrows Partnership for Children.

Advisory Committees

The DCFHE has established advisory committees and workgroups for many of its programs that include professional and consumer representation. Current DCFHE advisory and workgroups include the Childhood Immunization Action Coalition, Immunization Physician Advisory Committee, Successful Start Steering Committee and a newly formed adolescent transition team concerning systems development for children 9 years and older, WIC Vendor Advisory Council, Oral Health Advisory Council, Healthy Housing Collaborative, and newborn screening advisory committees. Newly developed committees supported by the DCFHE include the RI Prematurity Task Force, Healthy Homes Collaborative, Autism Spectrum Disorder Advisory Board, Injury Community Planning Group, Sexual Violence Prevention Planning Committee, the Tobacco Control Coalition, and the Eat Smart Move More-Health Promotion Policy Council.

F. Health Systems Capacity Indicators

Introduction

There are nine Health Systems Capacity indicators that Rhode Island uses as a self- assessment tool to inform public health systems development efforts. This section addresses an interpretation of the data, state level efforts to improve the health system indicators and strategies to continuously improve each indicator.

Health Systems Capacity Indicator 01: *The rate of children hospitalized for asthma (ICD-9 Codes: 493.0 -493.9) per 10,000 children less than five years of age.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	79.9	47.7	42.3	49.9	49.9
Numerator	512	294	260	304	304
Denominator	64080	61572	61397	60934	60934
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional

Notes - 2009

Data for 2009 are estimated and Denominator from the US Census Estimates

Notes - 2008

2008: Based on the 95% CI for the pediatric asthma hospitalization rates of Rhode Island children aged 0-4 for 2006, 2007 and 2008, the rate has remained stable. There has been no significant increase and no significant decrease.

Data for 2008 are provisional and Denominator from the US Census Estimates.

Notes - 2007

2007: Data reflect children aged 0 - 4.
Denominator from the US Census Estimates.

A change in the reporting method resulted in a lower number of events in the numerator. Prior to 2006, more than the primary diagnosis was used to identify children hospitalized for asthma. As of 2006, only the principal diagnosis is used. The CDC Asthma Control Program mandates that pediatric asthma hospitalizations, emergency department visits, and deaths, use the primary reason only.

Based on modified rates for for 2005 - 2007, the rate has remained stable.

Narrative:

In Rhode Island, the asthma hospitalization rate appears to have stabilized About 50% of the children who are hospitalized for asthma in Rhode Island live in one the state's culturally diverse, older, urban, "core" communities. The rate of asthma hospitalization for children under age five was 49,9% in 2009 (provisional) and has remained steady over the past four years.

Asthma is the number one chronic health condition in RI children, the third-ranked cause of hospitalization in children under age 15, and the leading cause of school absences. DCFHE works with the Community Asthma Programs at Hasbro Children's Hospital, and ALARI in implementing the pediatric elements of the state's asthma control plan. DCFHE also convenes

the Healthy Homes Collaborative to develop a plan create and maintain healthy housing in all communities. The Collaborative released "Healthy Housing: Why RI should invest in the vision." providing a brief overview of the impact that unhealthy housing has on health outcomes. The Healthy Housing and Asthma programs collaborate on the The Breathe Easy at Home project, designed to improve access and communication between medical homes for children with asthma, public health agencies and housing agencies.

The DCFHE provides technical assistance and support to the Newport County Healthy Communities Initiative, which is working with the Newport Housing Authority to launch a project titled Healthy Residents, Healthy Homes to ensure that every housing authority unit is environmentally sound and asthma- friendly and to connect residents of the housing authority with medical homes and specialty support services for asthma.

In addition, the DCFHE supports the work of a Parent Consultant in the Community Asthma Programs at Hasbro Children's Hospital to outreach to families of children with asthma to enroll them in asthma education classes, provided on-site at the hospital and in community settings. Priority populations for asthma education include children who have been discharged from the hospital or the emergency department and racially/ethnically diverse children living in urban environments.

First Connections Program home/environmental assessments were modified to be more comprehensive, encompassing healthy homes, asthma, and lead. The DFCHE is also collecting 'Healthy Housing Checklist' data submitted by certified lead centers, environmental lead inspectors and other home visitors.

The Tobacco Control Program received a CDC ARRA CPPW grant to coordinate a small city tobacco prevention and control project with the City of Providence Mayor's Substance Abuse Prevention Council to include a pilot smoke free Housing Authority policy and smoke free school campaign policy.

Health Systems Capacity Indicator 02: *The percent Medicaid enrollees whose age is less than one year during the reporting year who received at least one initial periodic screen.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	93.8	91.0	89.7	88.9	90.1
Numerator	12274	11717	11968	11674	11900
Denominator	13081	12878	13342	13135	13204
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2009

Data are provided by RI Department of Human Services the Center for Child and Family Health. Data for 2009 shows a slight increase in the percent of enrollees with at least one initial periodic screen compared to 2008.

Notes - 2008

Data are provided by RI Department of Human Services the Center for Child and Family Health. Data continues to show a decline since 2005. In 2005 the percent of enrollees with at least one initial periodic screen was 93.8 compared to 88.9 for 2008.

Notes - 2007
Data are provided by RI Department of Human Services the Center for Child and Family Health and indicate a decline in the percent of Medicaid enrollees less than 1 year old who received at least one intial periodic screen. Decline might be due to the enrollment of infants into the RIte Care Plan.

Narrative:
In Rhode Island, a majority of Medicaid enrollees receive one initial periodic screen before the age of one years old. In 2006, 91.%; in 2007, 89.7%; in 2008, 88.9% and 90.1% in 2009 (provisional)

Medicaid-eligible infants in Rhode Island are enrolled in one of three Medicaid managed care health plans. The RI Department of Human Services (DHS) monitors health plan performance and has developed mechanisms to reward the plans based on performance. Well-child visits within the first 15 months of life is one of the indicators used by DHS to evaluate health plan performance in the area of "Medical Home/Preventive Care".

The DCFHE works collaboratively with DHS and other partners to ensure children receive timely, quality preventive health care in the context of a medical home. The First Connections Program provides home visits to vulnerable newborns and their families. Home visitors link families to primary care providers and through parent education, stress the importance of well child visits in promoting healthy development. The Childhood Lead Poisoning Prevention Program works to ensure that all young children in RI receive lead screening as part of preventive well-child visits. Other DCFHE programs, including WIC and the Child Care Support Network, include messages about the benefits of preventive health care in their communications with parents and other caregivers. The DCFHE is also working with the RI Chapter of the American Academy of Pediatrics, DHS, and other partners to improve the content of well-child visits through increased rates of standardized developmental and behavioral health screening of infants and young children. The DCFHE with Successful Start launched Watch Me Grow RI, a program to support pediatric primary care providers to implement standardized developmental screening. The project provides tools and technical assistance to practices interested in implementing the screening.

KIDSNET collects data on newborn developmental, bloodspot and hearing screening. KIDSNET has been working with Successful Start to develop collection and appropriate sharing of developmental screening data. KIDSNET is working with Medicaid on implementing a data-sharing plan.

Health Systems Capacity Indicator 03: *The percent State Childrens Health Insurance Program (SCHIP) enrollees whose age is less than one year during the reporting year who received at least one periodic screen.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	100.0	0.0	0.0	0.0	90.0
Numerator	1	0	0	0	2971
Denominator	1	1	1	1	3301
Check this box if you cannot report the numerator because					

1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2009
Starting with 2009, Rhode Island children aged 0-8 were covered by CHIP [SCHIP].
Data are provided by RI Department of Human Services the Center for Child and Family Health and are estimated.

Notes - 2008
In Rhode Island, children in SCHIP are aged 8-18. Infants and
children less then 8 years old are enrolled in our Medicaid Managed Program [RiteCare]. This Health Systems Capacity Indicator does not apply to Rhode Island.

Notes - 2007
In Rhode Island, children in SCHIP are aged 8-18. Infants and
children less then 8 years old are enrolled in our Medicaid Managed Program [RiteCare]. This Health Systems Capacity Indicator does not apply to Rhode Island.

Narrative:
Rhode Island does not distinguish between Rite Care, Rhode Island Medicaid Managed Care and SCHIP. SCHIP is included in Rite Care. Ninety percent 90% of Medicaid including SCHIP enrollees whose age is less than one year received at least one periodic screen.

Medicaid-eligible infants in Rhode Island are enrolled in one of three Medicaid managed care health plans. The RI Department of Human Services (DHS) monitors health plan performance and has developed mechanisms to reward the plans based on performance. Well-child visits within the first 15 months of life is one of the indicators used by DHS to evaluate health plan performance in the area of "Medical Home/Preventive Care".

The DCFHE works collaboratively with DHS and other partners to ensure children receive timely, quality preventive health care in the context of a medical home. The First Connections Program provides home visits to vulnerable newborns and their families. Home visitors link families to primary care providers and through parent education, stress the importance of well child visits in promoting healthy development. The Childhood Lead Poisoning Prevention Program works to ensure that all young children in RI receive lead screening as part of preventive well-child visits. Other DCFHE programs, including WIC and the Child Care Support Network, include messages about the benefits of preventive health care in their communications with parents and other caregivers. The DCFHE is also working with the RI Chapter of the American Academy of Pediatrics, DHS, and other partners to improve the content of well-child visits through increased rates of standardized developmental and behavioral health screening of infants and young children. The DCFHE with Successful Start launched Watch Me Grow RI, a program to support pediatric primary care providers to implement standardized developmental screening. The project provides tools and technical assistance to practices interested in implementing the screening.

KIDSNET collects data on newborn developmental, bloodspot and hearing screening. KIDSNET has been working with Successful Start to develop collection and appropriate sharing of developmental screening data. KIDSNET is working with Medicaid on implementing a data-sharing plan.

Health Systems Capacity Indicator 04: *The percent of women (15 through 44) with a live birth during the reporting year whose observed to expected prenatal visits are greater than or equal to 80 percent on the Kotelchuck Index.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	2005	2006	2007	2008	2009
Annual Indicator	81.4	76.0	76.3	77.8	77.4
Numerator	9311	8915	8970	8789	8308
Denominator	11441	11733	11763	11295	10735
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2009
Data for 2009 is provisional and shows the trend in the percent of women excepted to have prenatal visits greater than or equal to 80 percent to remain the same as 2008.

Notes - 2008
Data for 2008 shows a increase in the percent of women excepted to have prenatal visits greater than or equal to 80 percent on the Kothechuck Index.

Notes - 2007
Data reflects calendar year and remained about the same as in 2007.

Narrative:
In Rhode Island, this percentage has decreased slightly since 2005 from 93.8% to 90.1% in 2009 (provisional) of women giving birth had observed to expected prenatal visits greater than or equal to 80% on the Kotelchuck Index.

Rhode Island continues to lead the country in women's access to prenatal care. Pregnant women with incomes up to 350% of the Federal Poverty Level are eligible for RIte Care, which provides a comprehensive pregnancy benefit package. The DCFHE works to increase access to prenatal care through the Women's Health Screening & Referral Program (WHSRP) and the First Connections Program. WHSRP provides comprehensive health risk screening to women receiving pregnancy tests at Family Planning Program clinics. The health screen is designed to help women identify risks that could harm their baby or themselves during a pregnancy. Agencies help connect women to the services they need early in pregnancy, or before a pregnancy, to improve the health of the mother and her baby. The First Connections Program currently offers services to at-risk pregnant women on a limited basis. An evaluation of the program was completed in FY2006, which included recommendations such as increased outreach to at-risk pregnant women to provide education, support, and ensure that women are linked to a source of prenatal care. The DCFHE is currently implementing an intensive home visiting model.

Health Systems Capacity Indicator 07A: *Percent of potentially Medicaid-eligible children who have received a service paid by the Medicaid Program.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	2005	2006	2007	2008	2009

Annual Indicator	85.1	82.9	84.1	82.4	83.2
Numerator	91144	90731	88641	84717	89746
Denominator	107144	109411	105365	102774	107887
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2009
Data is are estimated.
Source of data: Department of Human Services and reported in 2010 Rhode Island Kids Count Factbook.
Data is reporting children under the age of 19 receiving Medical Assistance

Notes - 2008
Data is are estimated.
Source of data: Department of Human Services and reported in 2009 Rhode Island Kids Count Factbook.
Data is reporting children under the age of 19 receiving Medical Assistance.

Notes - 2007
Data is are estimated.
Source of data: Department of Human Services and reported in 2008 Rhode Island Kids Count Factbook.
Data is reporting children under the age of 19 receiving Medical Assistance.

Narrative:
Approximately 83% of children eligible for Medicaid/SCHIP in Rhode Island accessed the program in 2009. This percentage has remained consistent over the last four years.

Rhode Island is committed to ensuring that all children have access to insurance and quality health care. The state supports outreach to eligible populations through a variety of mechanisms, including a toll-free RIte Care information line at DHS and promotional activities carried out by each of the three RIte Care managed care health plans (television advertisements, billboards, etc.). The DCFHE manages several programs designed to facilitate access to RIte Care by eligible children and families including WIC, Childcare Support Network, and the First Connections Program, refer families who are uninsured or underinsured directly to Medicaid.

DCFHE is providing technical assistance to several local CATCH projects and community coalitions in the cities of Woonsocket, Newport, Westerly and the Olneyville neighborhood in Providence. These groups are working at the local level to build the capacity of medical homes, including developing models for adolescent medical homes, and to link children and families to needed health and human services. DCFHE has found that models for adolescent medical home is a promising way to provide access to care across the State. The DCFHE is exploring opportunities to provide a sustainable infrastructure for on-site support and referrals to help schools identify and address mental and behavioral health issues through the establishment of a Mental Behavioral Health Care Resource Center for RI schools in partnership with the RI Public Health Institute. . Finally, the DCFHE is a key partner in Covering Kids Rhode Island, a coalition of partners working statewide and in local project communities to ensure that all children and adults eligible for RIte Care or RIte Share are enrolled and retain their coverage. KIDSNET is working with the Department of Human Services to exchange child health data.

Health Systems Capacity Indicator 07B: *The percent of EPSDT eligible children aged 6 through 9 years who have received any dental services during the year.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	58.7	62.0	67.5	70.5	70.4
Numerator	12033	12392	13043	14976	12857
Denominator	20484	19976	19309	21250	18254
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2009
Data are provided by RI Department of Human Services the Center for Child and Family Health. Approximately 70% of Medicaid children age six through nine receiving dental care in 2009.

Notes - 2008
Data are provided by RI Department of Human Services the Center for Child and Family Health. This indicator's upward trend continues in 2008, with approximately 70% of Medicaid children age six through nine receiving dental care.

Notes - 2007
Data are provided by RI Department of Human Services the Center for Child and Family Health. The upward trend for this indicator went from 62.0% in 2006 to 67.5%.

Narrative:
In Rhode Island, this percentage is increasing from 62% in 2006, 67.5% in 2007, 70.5% in 2008 and 70.4 % in 2009 (provisional) As the RI Department of Human Services (DHS) continues to work to improve the existing state infrastructure for providing dental services for Medicaid eligible populations, it is expected that this percentage will increase over time.

The First Connections Home Visiting/ WIC programs provide culturally appropriate information about early childhood caries/prevention. The Child Care Support Network, Child Care Health Consultants offers health consultation to child care centers conducting child health record reviews, providing staff training and technical assistance, distributing educational materials, and working directly with families to provide referrals to community services and resources..

School-based dental/sealant programs are located in several Rhode Island communities. The Association of State and Territorial Dental Directors (ASTDD), recommends that schools with 50% or more students eligible for free or reduced school meals (FRL) programs are targeted for school-based services. Currently, 34% (n=67) of RI elementary schools meet eligibility criteria but are not associated with a school-based dental/sealant program. Two school based health centers refer adolescents to oral health services as necessary.

Health Systems Capacity Indicator 08: *The percent of State SSI beneficiaries less than 16 years old receiving rehabilitative services from the State Children with Special Health Care Needs (CSHCN) Program.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	2005	2006	2007	2008	2009
Annual Indicator	7.9	0.0	0.0	0.0	0.0
Numerator	296	0	0	0	0
Denominator	3768	1	1	1	1
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

Notes - 2009
Please note that this health system capacity indicator does not apply to Rhode Island.

The Rhode Island Department of Health has not in the past year paid for any rehabilitation services through the CSHCN Program for three primary reasons. (1) The Early Intervention Program [EI] transferred to the Department of Human Services and a private insurance mandate passed in 2005. (2) The State in late 2005, eliminated carve-out funding of services for children and youth with complex special needs, and requested insurers to reimburse for these services. (3) SSI recipients are enrolled in Medicaid which funds rehabilitation services

Notes - 2008
Please note that this health system capacity indicator does not apply to Rhode Island.

See Note in 2007 for complete explanation.

Notes - 2007
Please note that this health system capacity indicator does not apply to Rhode Island.

The Rhode Island Department of Health has not in the past year paid for any rehabilitation services through the CSHCN Program for three primary reasons. (1) The Early Intervention Program [EI] transferred to the Department of Human Services and a private insurance mandate passed in 2005. (2) The State in late 2005, eliminated carve-out funding of services for children and youth with complex special needs, and requested insurers to reimburse for these services. (3) SSI recipients are enrolled in Medicaid which funds rehabilitation services.

Narrative:
Rhode Island is a 1914A state and all children on SSI are enrolled in Medicaid. Medicaid benefits are extensive and include rehabilitative services. The CSHCN Program does not provide direct services. It is the goal of CSHCN Program to build resources in the community and sustain the provision of services for children with complex medical needs to other systems of care.

This health systems capacity indicator does not apply to Rhode Island.

Health Systems Capacity Indicator 05A: *Percent of low birth weight (< 2,500 grams)*

INDICATOR #05 *Comparison of health*	YEAR	DATA SOURCE	POPULATION		
			MEDICAID	NON-	ALL

system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State				**MEDICAID**	
Percent of low birth weight (< 2,500 grams)	2008	payment source from birth certificate	9.2	6.4	8

Notes - 2011
There are a total of 958 Resident infants born in 2008 weighting lt 2500 grams. Of the 958 LBW infants, insurance at birth was unknow for 24.

Narrative:
Using birth certificate data, the percent of low birth weight infants (< 2,500 grams) for Medicaid, non-Medicaid, and all MCH populations in the state in 2008 was higher for the Medicaid population (9.2%) than it was for the non-Medicaid population (6.4%). Disparities remains between recipients of Medicaid and those insured by other means. (7.5%).

DCFHE is working to reduce the number of low birth weight infants born in RI, targeting specific interventions to high-risk populations. The WHSRP targets at-risk populations utilizing services at Title X Family Planning Clinics. Women who receive positive pregnancy tests through the clinics are referred to medical and community services. The WIC Program provides nutrition assessments, coordination of care, education, and nutritious foods to low-income pregnant women (the majority of whom are enrolled in RIte Care) to promote healthy pregnancies and healthy births. Finally, the DCFHE, in partnership with Woman and Infants Hospital of Rhode Island, supports the RI Task Force on Premature Birth and recommends policies, and programs to reduce low birth weight. The Tobacco Control Program participates on the RI Task Force on Premature Birth and provides funds to train providers to refer pregnant women to cessation services.

Health Systems Capacity Indicator 05B: *Infant deaths per 1,000 live births*

INDICATOR #05 ***Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State***	**YEAR**	**DATA SOURCE**	**POPULATION**		
			MEDICAID	**NON-MEDICAID**	**ALL**
Infant deaths per 1,000 live births	2008	payment source from birth certificate	6.7	4.8	5.9

Notes - 2011
Since 2000, Rhode Island's Resident Infant Mortality was it's lowest in 2004 at 5.3%. Provisional data for 2008 indicate that RI's infant mortality rate has declined to 5.9% compared to 7.3% for 2007.

Of the 71 infant deaths for 2008, insurance status for 4 infant deaths was unknown.

Narrative:
Using birth certificate data, the percentages of infant deaths per 1,000 live births in 2008 was higher for Medicaid populations at 6.7% as compared to non-Medicaid populations (4.8%). RI's infant mortality rates appear to fluctuate significantly due to the small number of infant deaths

each year. RI's infant mortality rate (for all populations) has remained stable.

A multitude of factors are associated with infant mortality, including poor health of the mother, inadequate prenatal care, birth defects, and a host of socioeconomic factors (e.g. low-income, low levels of education). The Pregnancy Risk Assessment Monitoring System (PRAMS) collects information to improve the health of mothers and infants by reducing poor pregnancy outcomes such as low birth weight, infant mortality and morbidity, and maternal morbidity. PRAMS is an ongoing survey of recent mothers to learn about their behaviors and experiences before, during, and after pregnancy. PRAMS over-samples births in the core cities of Central Falls, Newport, Pawtucket, Providence, West Warwick, and Woonsocket. These cities have more than 15% of children living in poverty and are home to large numbers of women and families insured through Medicaid. Information gathered through the survey provides information on maternal and infant well being in RI. PRAMS data are used to: increase understanding of maternal behaviors and experiences and their relationship to adverse pregnancy outcomes; identify groups of women and infants at high risk for health problems; monitor changes in health status indicators such as unintended pregnancy, prenatal care, breastfeeding, smoking, drinking, and infant health; measure progress towards local, state, and national goals for improving the health of mothers and infants; develop new, and modify existing, maternal and child health programs; help health professionals incorporate new research findings into standards of practice; and influence public health policy. HEALTH also manages efforts to identify newborns at-risk for serious disease or disability and provide necessary follow-up care. The Rhode Island Birth Defects Program identifies newborns with birth defects, ensures that these children receive services and treatment on a timely basis, and monitors trends over time. The Newborn Screening Program currently tests infants at birth for 29 genetic, and sometimes life-threatening, conditions. First Connections Program nurses provide immediate, family-centered follow-up for any newborn testing positive for one of these conditions. In addition to screening for genetic conditions, newborns are also screening for developmental risks. Families of newborns screening positive for risk are offered home visits through the First Connections Program.

Health Systems Capacity Indicator 05C: *Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester*

INDICATOR #05 ***Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State***	**YEAR**	**DATA SOURCE**	**POPULATION**		
			MEDICAID	**NON-MEDICAID**	**ALL**
Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester	2008	payment source from birth certificate	74.1	88.9	81.9

Notes - 2011
Total number of Rhode Resident moms receiving prenatal care in the first trimester in 2008 is 9539. Insurance status is unknown for 311 of these moms.

Narrative:
Using birth certificate data, the percent of infants born to pregnant women receiving care in the first trimester in 2008 was lower for Medicaid populations (74.1%) as compared to non-Medicaid populations (88.9%). There has been little change in this indicator since last year and this number is decreasing from a high of 84% of pregnant women on Medicaid receiving prenatal care in

2004.

The DCFHE supports numerous activities targeted at ensuring women access prenatal care early in their pregnancy, including WHSRP and WIC programs.

Health Systems Capacity Indicator 05D: *Percent of pregnant women with adequate prenatal care(observed to expected prenatal visits is greater than or equal to 80% [Kotelchuck Index])*

INDICATOR #05 ***Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State***	**YEAR**	**DATA SOURCE**	**POPULATION**		
			MEDICAID	**NON-MEDICAID**	**ALL**
Percent of pregnant women with adequate prenatal care(observed to expected prenatal visits is greater than or equal to 80% [Kotelchuck Index])	2008	payment source from birth certificate	69.5	85.2	77.8

Notes - 2011
For 2008, insurance status was missing for 289 women of the 8789 women that received adequate prenatal care using the Kotelchuck Index.

Narrative:
Using birth certificate data, the percentage of pregnant women with adequate prenatal care (observed to expected prenatal visits is greater than or equal to 80% of the Kotelchuck Index) in 2008 was lower for Medicaid populations (69.5%) as compared to Non-Medicaid populations (85.2%). The performance on this indicator declined slightly for the Medicaid population.

The DCFHE supports numerous activities targeted at ensuring women access appropriate prenatal care, including the WHSRP and WIC programs.

Health Systems Capacity Indicator 06A: *The percent of poverty level for eligibility in the State's Medicaid and SCHIP programs. - Infants (0 to 1)*

INDICATOR #06 **The percent of poverty level for eligibility in the State's Medicaid programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL Medicaid**
Infants (0 to 1)	2009	250
INDICATOR #06 **The percent of poverty level for eligibility in the State's SCHIP programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL SCHIP**
Infants (0 to 1)	2009	133

Notes - 2011

Medicaid eligibility levels:
Infants qualify if <250% of Poverty Level.
Children (1-18) qualify if <100% of Poverty Level.
Pregnant/Postpartum Women qualify if < 185% of Poverty Level.

Notes - 2011
SCHIP [CHIP] eligibility levels:
Infants qualify for partial funding if > 133% Poverty Level
Children (1-8) qualify for partial funding if > 133% Poverty Level
Children (8-18) qualify if 100 - 250% Poverty Level
Pregnant/Postpartum Women (8-18) qualify if 185-250% of Poverty Le

Narrative:
Infants (0-1) qualify for Medicaid if <250% of the federal poverty level (FPL). SCHIP does not include infants.

Eligibility for Medicaid and SCHIP have not changed. Rhode Island continues to enjoy one of the lowest rates of uninsured among children in the country. In 2009, a total of 89,746 children under the age of 19 were enrolled in Medicaid.

The DCFHE supports access to Medicaid through WIC, Childcare Support Network, and the First Connections Program, refer families who are uninsured or underinsured directly to Medicaid.. All WIC applicants are screened for health insurance, and referred as needed to Medicaid. In 2009, RIte Care enrollment among WIC participant infants (0-12 months) was 75% down from 82.5% in 2008.

Health Systems Capacity Indicator 06B: *The percent of poverty level for eligibility in the State's Medicaid and SCHIP programs. - Medicaid Children*

INDICATOR #06 **The percent of poverty level for eligibility in the State's Medicaid programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL Medicaid**
Medicaid Children (Age range 1 to 18) (Age range to) (Age range to)	2009	100
INDICATOR #06 **The percent of poverty level for eligibility in the State's SCHIP programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL SCHIP**
Medicaid Children (Age range 1 to 8) (Age range 8 to 18) (Age range to)	2009	133 250

Narrative:
Children (1-18) qualify for Medicaid if <250% of the FPL. Children (8-18) qualify for SCHIP if <250% of the FPL.

Eligibility for Medicaid and SCHIP have not changed. Rhode Ilsand does not have a separate SCHIP PRogram rather all elegible chidlren are included in RIte Care, the State's Medicaid program. Rhode Island continues to enjoy one of the lowest rates of uninsured among children in the country. In 2009, a total of 89,746 children under the age of 19 were enrolled in Medicaid.

The DCFHE supports access to Medicaid through WIC, Childcare Support Network, and the First Connections Program, refer families who are uninsured or underinsured directly to Medicaid.. All WIC applicants are screened for health insurance, and referred as needed to Medicaid. In 2009, RIte Care enrollment among WIC participant infants (0-12 months) was 75% down from 82.5% in 2008.

Health Systems Capacity Indicator 06C: *The percent of poverty level for eligibility in the State's Medicaid and SCHIP programs. - Pregnant Women*

INDICATOR #06 **The percent of poverty level for eligibility in the State's Medicaid programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL Medicaid**
Pregnant Women	2009	185
INDICATOR #06 **The percent of poverty level for eligibility in the State's SCHIP programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL SCHIP**
Pregnant Women	2009	250

Narrative:
Pregnant/postpartum women qualify for Medicaid if their income is <185% of FPL. Pregnant/postpartum women qualify for SCHIP if their income is between 185-250% of FPL. Parents of Medicaid or SCHIP-eligible children with incomes between 100% and 185% of FPL are eligible for SCHIP. Families with incomes >150% of FPL are subject to a family partial premium. The premium threshold increases to 185% for families consisting of only pregnant women and infant(s). In Rhode Island, there is also state funded program for pregnant women with income between 251% and 350% of FPL. Under this program, which requires a premium, the state funds the cost of labor and delivery only.

The DCFHE supports pregnant women's access to Medicaid through WIC, Childcare Support Network, and the First Connections Program, refer families who are uninsured or underinsured directly to Medicaid.. All WIC applicants are screened for health insurance, and referred as needed to Medicaid. In 2009, RIte Care enrollment among WIC participant infants (0-12 months) was 75% down from 82.5% in 2008.

The WHSRP targets at-risk populations utilizing services of Title X Family Planning clinics. The program identifies health risks among women and connects women to medical and community services, including RIte Care.

Health Systems Capacity Indicator 09A: *The ability of States to assure Maternal and Child Health (MCH) program access to policy and program relevant information.*

DATABASES OR SURVEYS	**Does your MCH program have the ability to obtain data for program planning or policy purposes in a timely manner? (Select 1 - 3)**	**Does your MCH program have Direct access to the electronic database for analysis? (Select Y/N)**
ANNUAL DATA LINKAGES Annual linkage of infant birth and infant death certificates	3	Yes

Annual linkage of birth certificates and Medicaid Eligibility or Paid Claims Files	1	No
Annual linkage of birth certificates and WIC eligibility files	3	Yes
Annual linkage of birth certificates and newborn screening files	3	Yes
REGISTRIES AND SURVEYS Hospital discharge survey for at least 90% of in-State discharges	3	Yes
Annual birth defects surveillance system	3	Yes
Survey of recent mothers at least every two years (like PRAMS)	3	Yes

Notes - 2011

Narrative:
The DCFHE links birth and infant death data from vital records on an annual basis. Birth data are also linked to WIC eligibility and newborn screening files. KIDSNET allows the DCFHE to also link birth data with newborn developmental risk screening, newborn hearing, immunization, lead screening, environmental inspections for children with elevated blood lead levels early intervention, and home visiting data.

The DCFHE has the ability to obtain data for program planning and policy purposes in a timely manner from the following registries/surveys: hospital discharge data for at least 90% of in-state discharges, PRAMS, and Birth Defects Surveillance. It does not have the ability to obtain annual data linking birth certificates and Medicaid eligibility or paid claims files, electronically or otherwise, at this time. KIDSNET and the Department of Human Services have a signed data sharing agreement and are working to implement a plan to exchange data relevant to policy and planning.

MCH data are collected, analyzed and disseminated to drive policy development and program enhancements. Data sources include, but are not limited to: KIDSNET, Vital Records, hospital inpatient and emergency department visit data, surveys (PRAMS, TWOS, YRBS, and BRFSS), Birth Defects. Most of these data sources can identify insurance status.

Health Systems Capacity Indicator 09B: *The Percent of Adolescents in Grades 9 through 12 who Reported Using Tobacco Product in the Past Month.*

DATA SOURCES	**Does your state participate in the YRBS survey? (Select 1 - 3)**	**Does your MCH program have direct access to the state YRBS database for analysis? (Select Y/N)**

Youth Risk Behavior Survey (YRBS)	3	Yes
School Accountability for Learning and Teaching [SALT]	3	No
Youth Tobacco Survey	3	No

Notes - 2011

Narrative:
HEALTH participates in the Youth Risk Behavior Survey (YRBS) and the DCFHE has direct access to the YRBS database for analysis. The state also participated in the School Accountability for Learning and Teaching (SALT) Survey ending in 2009 and had participated in the Youth Tobacco Survey until 2005. The DCFHE does not have direct access to either the SALT or Youth Tobacco Survey databases for analysis. Rhode Island no longer particpates in the Youth Tobacco Survey.

DCFHE participated in the development of RIDE's Surveyworks, replacing the SALT survey and providing school level data on a host of issues related to teaching and learning including health concerns. A few questions from the YRBS are included in Surveyworks to allow for local comparison of state level data. DCFHE will be able to access data directly from Surveyworks in the near future.

The DCFHE produces user-friendly data tools that combine and compare multiple data sources to identify determinants of youth risk behaviors such as tobacco use.

In FY 2010 the Tobacco Control Program received a CDC ARRA CPPW state-level grant which will be used to increase community support to strengthen and close loopholes in the state youth tobacco access law and ensure the state law is consistently enforced throughout the state. The TCP also received a CDC CPPW community level grant to coordinate a small city tobacco project with t he Providence Mayor's Substance Abuse Prevention Council. The initiative will include new city ordinances restricting tobacco marketing to youth, tobacco vendor density and proximity to schools, and initiate Providence Public School based policies creating smoke free campuses and restricting tobacco sponsorship. Providence youth will be included in media campaign and enforcement strategies.

IV. Priorities, Performance and Program Activities

A. Background and Overview

Results from the statewide needs assessment results, state and national performance measures, capacity indicators, and community stakeholders' input provide a comprehensive view of the MCH needs in Rhode Island. DCFHE identified state priorities and associated State Performance Measures from quantitative and qualitative information. The state priorities represent the four levels of the MCH pyramid and all MCH population groups. The capacity to address significant public health challenges at various service levels in an integrated way is a special mandate of Title V. DCFHE is proud of its coordinated, leveraged, and evaluated investments in community care for children and their families across the state.

For FY2011, the DCFHE developed new state priorities and State Performance Measures based on its comprehensive needs assessment and the community input received in FY2010. The new state priorities and State Performance Measures for FY2011 areas follows:

Priority: Expand capacity and access to parent education and family support programs.
SPM1: Increase the number of RI resident families with at-risk newborns that receive a home visit during the newborn period (<=90 days).

Priority: Reduce tobacco initiation among middle school students.
SPM2: Reduce tobacco initiation among middle school students.

Priority: Increase the percentage of adolescents who have a preventive "well care" visit each year.
SPM3: Increase the percentage of adolescents who have a preventive "well care" visit each year.

Priority: Increase the social and emotional health of children and youth with special health care needs.
SPM 4 Decrease the percentage of high school students with disabilities who report feeling sad or hopeless.

Priority: Increase the percentage of women who have a preventive care visit in the last year.
SPM 5: Increase the percentage of women who have a preventive care visit in the last year

Priority: Initiate prenatal home visiting program.
SPM6: Initiate prenatal home visiting program.

Priority Promote use of evidence based programs to support parents and families
SPM 7 Increase the number of parents with children in early childhood that enroll in parenting education/support programs.

Priority: Adopt the social determinants of health into public health practice.
SPM 8: Decrease the number of Rhode Island adolescents who report food insecurity
SPM 9: Increase the number of Rhode Island high school students who earn a high school diploma or diploma equivalent in the six core cites.

All of the State Performance Measures are new with the exception of SPM 1. This measure is a modified version of former SPM 3. The modification reflects the current efforts in Rhode Island's home visiting initiatives. State Performance Measures 2-6 mirror the identified priorities reflected in the themes based on statewide data and community input. State Performance Measures 1 and 7 are related priorities based on a life course approach for prioritizing health care needs and services by looking at health and wellness across the lifespan. The measures are for specific populations. Our intent and purpose is to have an overarching priority across all MCH population groups. State Performance Measures 8 and 9 are indicators of the social determinants of health.

Most health disparities affect groups that are disadvantaged or marginalized due to socioeconomic status, race/ethnicity, gender, sexual orientation, disability status, geographic location, or any combination of these. Access to healthy food and quality education are social determinants that contribute to good health.

These new state priorities and corresponding performance measures, along with the 18 National Performance Measures are collectively designed to positively impact the six National outcomes measures including: (1) perinatal mortality, (2) infant mortality, (3) neonatal mortality, (4) postneonatal mortality, (5)child mortality, and (6) infant death disparity. The new State Performance Measures are short-term precursors for the National outcome measures. All six National outcome measures focus on mortality among our most vulnerable populations yet, within the context of State and National Performance Measures, the necessity and breadth of a life course approach is evident to reach these goals. Also, DCFHE's commitment and emphasis to include efforts across both the MCH and health equity pyramids, demonstrates our commitment to reduce disparities and achieve health equity for all Rhode Islanders.

This section will illustrate how the DCFHE will be accountable for maternal and child health efforts supported by the Maternal and Child Health Block Grant. Measuring progress toward successful achievement for each individual performance measure includes: budgeting and expending funds over the four levels of the MCH and health equity pyramids, positively impacting the six National outcome measures. This section also includes the FY 2010 Annual Report on 18 National Performance Measures and the 10 former State Performance Measures.

B. State Priorities

This section describes the relationship of the State priorities, National and State performance measures along with the capacity and resource capability of HEALTH's DCFHE, as the State Title V administrator. This discussion pertains to the new State priorities and performance measures developed in 2010.

DCFHE uses a life course development approach that addresses the determinants of health as its framework for health planning. Social, political and economic policies and conditions evolve and determine health outcomes. While HEALTH has made significant progress in meeting Title V measures and Healthy People 2010 goals, disparities still exist. Therefore, proactive and applied public health strategies focus on all members of the community to eliminate health disparities in Rhode Island. It is through this collective work effort that DCFHE offers quality programs and continues to assure that all Rhode Islanders will achieve optimal health throughout the lifespan via a statewide system of services that are comprehensive, community-based, coordinated and family-centered. This approach links with the MCH needs assessment and program narrative to form the basis of our work in this application.

State priorities were developed in 2010 as part of the five-year needs assessment. All nine state priorities address significant needs identified through data analysis and community input. The DCFHE has assessed internal capacities as well as external resources to meet these needs. State Performance Measures were developed for each of the new priorities, along with a statement of significance for each measure. Where appropriate, selected example activities under each priority will address each level of both the MCH and Health Equity pyramids as discussed in detail in the Needs Assessment. Attention to each level of the pyramid ensures that individual; family/community; and systems needs are addressed to create healthful environments to support maternal and child health. In addition, many of the state priorities directly relate to the National Performance Measures.

Priority: Expand capacity and access to parent education and family support programs.
SPM1: Percent of RI resident families with at-risk newborns that receive a home visit during the

newborn period (<=90 days). Related National Performance Measures include: 1, 12, 15, 17, 18.

This measure is the former State Performance Measure 3 revised to reflect the expanded home visiting efforts in Rhode Island. There are gaps in services for families with young children to provide parent education and family support. These are needed to improve outcomes.

This priority is in both infrastructure building and social determinants of health level of the MCH and Equity pyramids. Parent education and support programs can assist families in connecting to and accessing enabling and population based services. Empowered parents can assess their child's development and advocate for needed services, as well as work to change the context of health choices as the default option within individual home and in community-based settings that serve children and their families.

Priority: Reduce tobacco initiation among middle school students.
SPM2: Percent of middle school students who have initiated tobacco use. Related National Performance Measures include: 5, 13, 15.

The tobacco industry is losing its customer base as adults quit smoking and/or die of smoking related illnesses. To ensure a steady stream of tobacco users, tobacco companies target young people with very seductive marketing campaigns. Prevention of youth initiation will ensure fewer youth will become addicted to tobacco in adulthood.

The priority is in both the infrastructure building and social determinants of health portion of the pyramids. Strategic policy development can eliminate access to tobacco for minors. Additionally, population based services like health education can inform youth about tobacco and create environments where healthy choices are the default choice. Direct health care services and education and counseling could include the development of evidence-based approaches to support youth who have initiated tobacco use already.

Priority: Increase the percentage of adolescents who have a preventive "well care" visit each year.
SPM3: Percent of adolescents who have a preventive "well care" visit each year. Related National Performance Measures include: 2,3,4,5, 6,8,10,13,16.

Rhode Island has a low rate of uninsured children including adolescents. This measure includes only adolescents enrolled in health plans however, children who are not insured most likely do not receive preventive care. Health plans in Rhode Island report HEDIS measures including adolescent well care visits for their enrolled populations. Even though, only 7% of Rhode Island's children under age 18 were uninsured between the time period of 2006-2008, approximately 40% of adolescents did not receive a well care visit in the previous year as per the HEDIS measure. There was no difference between private and public health insurance plans in terms of adolescent well care visit. The HEDIS national benchmark measure for adolescent well care visits is under 60% that may explain why the health care utilization for adolescent well care is not better.

This measure effects all levels of both pyramids as health insurance can provide access to care yet it does not guarantee that adolescents will utilize the care. Direct health care such as provider practices (eg adolescent friendly, wellness promotion/risk reduction versus traditional visit), enabling services such as health plan incentives (eg use of services by enrolled members), population based services such as youth and parent engagement strategies (support for visit, and how it aligns with adolescent developmental needs) as well as infrastructure building policies (such as required physical for high school and a more rigorous HEDIS measure) to increase the number of adolescents receiving well child visits needs to be considered to develop supportive systems of care for adolescents thereby addressing social determinants of health.

Priority: Increase the social and emotional health of children and youth with special health care

needs.
SPM 4 Percent of high school students with disabilities who report feeling sad or hopeless. Related National Performance Measures include: 2, 3, 4, 5, 6.

The behavior risk status of RI's youth with special needs is of great importance to state and local policy leaders from health, education, human services and juvenile justice. Data from the YRBS indicate that students with disabilities are more likely to start earlier and currently smoke cigarettes, drink alcohol, and use marijuana; more likely to be threatened, physically fight, be forced to have sex, and not go to school due to feeling unsafe; more likely to get insufficient physical activity and more likely to be overweight. Further, students with disabilities are more likely to report feelings of hopelessness and to consider and attempt suicide than their non-disabled peers. Although many students in RI participate in risky behaviors, the data indicate that students with disabilities participate in these behaviors earlier, more consistently, and to a more dangerous level than their peers. The Office of Special Health Care Needs in the Health Disparities and Access to Care Team leads the charge in highlighting the risk behaviors of students with disabilities and systematically addressing them through the levels of the MCH and Equity pyramids by increasing the following: infrastructure building services such as well-integrated academic interventions; enabling services such as positive social and recreational activities; populations and individual based education and counseling programs that support self-determination and student leadership; and direct health care interventions that address behavioral health concerns.

Priority: Increase the percentage of women who have a preventive care visit in the last year.
SPM 5: Percent of women who have a preventive care visit in the last year. Related National Performance Measures include: 6, 8, 15, 16, 18.

This priority is expected to improve health outcomes by improving the focus on prevention, reducing the likelihood of developing a chronic disease, and increasing utilization of primary care as women establish a relationship with a primary care provider. This may also reduce health care costs by reducing utilization of the emergency department for preventable conditions.

The Women's Health Advisory Committee advises HEALTH's Office of Women's Health on statewide priorities and policies to address social determinants of health as well as build infrastructure to support women's health. It envisions a Rhode Island where women live to their optimal level by achieving an ideal state of health by promoting a gender-informed, coordinated, comprehensive, primary prevention approach to women's health across the lifespan. Work is targeted to eliminate health disparities across all dimensions of age, ability, geography, race, ethnicity, sexual orientation, economics and education. Enabling services for children and families can assist women in accessing necessary care. Accessing direct health care services and clinical interventions can ensure all women are able to achieve optimal health.

Also, the RI Task Force on Premature Births made recommendations addressing all levels of the MCH and healthy equity pyramids including: meeting the state's standards for comprehensive family life and sexuality education in schools, expanding access to emergency contraception for all women, supporting state policies and programs that ensure access to comprehensive primary and preventive health care services for women, expanding the range of services in all settings where women, receive health care to include improved identification of health risks, health information, and referrals for health risks associated with preterm birth, and enhancing comprehensive, relationship family support programs to improve outcomes for women and their children and prevent subsequent teen pregnancy.

Priority: Initiate prenatal home visiting program.
SPM6: Percent of pregnant women delivering babies served by home visiting. Related National Performance Measures include: 4, 5, 8, 11, 12, 13, 14, 15, 17, 18.

Rhode Island has high rates of prematurity and low birth weight rates, as well as, high rates of

infant mortality in participating core cities. Rhode Island has limited home visiting capacity to serve pregnant women using an evidence-based model.

Currently First Connections Home Visiting Program provides direct health care, education and counseling, through four community based agencies to almost 50% of families with newborns who have specific risk profiles created from information collected at birthing hospitals. Home visitors provide general parenting information, conduct home assessments, and educate parents about infant care, and link families to appropriate resources. The DCFHE is implementing an intensive home visiting model as well as prenatal home visiting through First Connections in an effort to build a strong infrastructure for home visiting as well as to inform polices that affect the social determinants of health for participating families served.

Priority Promote use of evidence based programs to support parents and families
SPM 7 Number of parents with children in early childhood that enroll in parenting education/support programs. Related National Performance Measures include: 1, 2, 4, 7, 9, 11, 12, 13,14, 15, 17.

This priority is overarching across all of the MCH population groups although the measure is specific to early childhood. More evidence based programs that demonstrate outcomes are needed to ensure that resources are allocated to programs that improve outcomes. Evidence based programs can address the social determinants of health by building the knowledge and skills of parents to address their families' needs. Additionally evidence based program approaches can help inform policy development to strengthen the State's capacity and infrastructure to support families.

Priority: Adopt the social determinants of health into public health practice.
SPM 8: Percent of Rhode Island adolescents who report food insecurity. Related National Performance Measures include: 5, 9, 11, 13, 14, 17, 18.

Food insecurity is a proxy measure for poverty. Income is a social determinant of health status. McDonough et al. used data from the Panel Study of Income Dynamics for the years 1968 to 1989; they used fourteen ten-year panels to analyze predictors during the first five years and vital indicators during the second five years of each panel. They found that "Income level was a strong predictor of mortality, especially for persons under the age of 65" and they concluded that "income and income stability should be addressed in population health policy" (McDonough et al., 1997, p. 1476).

This priority is overarching across all MCH populations and reflects a lifecourse perspective. Direct health care and education can help inform healthy nutritional choices and advocacy for access to healthful choices. Enabling services such as transportation can help ensure access. Policies that limit access to unhealthy food and increase access to healthy choices create an infrastructure that support health practices as the default choice.

Priority: Adopt the social determinants of health into public health practice.
SPM 9: Percent of Rhode Island high school students who earn a high school diploma or diploma equivalent in the six core cites. Related National Performance Measures include: 2, 3, 4, 5, 6, 8, 9, 10, 12, 13, 14, 15, 16, 17, 18.

Grossman and Kaestner cite a number of studies (Auster et al., 1969; Grossman, 1972; Grossman, 1975; Grossman & Benham, 1974; Silver, 1972) that suggest, "years of formal schooling completed is the most important correlate of good health" (Grossman & Kaestner, 1997, p. 73). Their examples show schooling to be a more important determinant of health than income or occupation, and this holds true when controlling for the reverse causality occurring when poor health leads to poverty.

This priority is overarching across all MCH populations and reflects a lifecourse approach. The

interrelationship between health and academic achievement is cyclical. Children who come to school ready to learn become children who leave school ready to lead productive lives which is why increasing the high school graduation rate to 90% is an official health objective for the nation for the year 2010 (U.S. DHHS, 2006). Children who are healthy can learn better. Children who enjoy learning are more likely to stay in school. Children who stay in school have better health outcomes in their adult lives. Adults who practice healthful behaviors can teach children the value of a healthy lifestyle (Bogden, 2003). School and community based efforts, along with the development of polices and systems of care will address every level of the MCH and Equity pyramids to ensure positive health outcomes across the MCH populations.

Priorities, Capacity and Resource Allocation

After the development of the priorities, activities and projects are identified to address the priority strengths and needs through the Venture Capital Request (VCR) process. The VCR's describes the activity or project and includes required MCH information on how the VCR aligns with one or more of the set priority or priorities, type of population and type of service data, how the VCR will be measured and how it aligns with the application process or measures.

In addition, VCR reflects the four pillars of Community, Family Health and Equity's (CFHE) new approach for public health: health equity, the social and environmental determinants of health, the life course approach and integrations of programs. MCH Block grant resources are allocated based on the interventions from the health equity framework. This ensures that Federal Maternal and Child Health Block Grants funds are utilized to improve maternal and child health, reduce disparities and achieve health equity for all Rhode Islanders. The DCFHE, as the designated Title V administrator for Rhode Island, looks forward to developing capacity and expertise to address these priorities and measures over the next five years.

C. National Performance Measures

Performance Measure 01: *The percent of screen positive newborns who received timely follow up to definitive diagnosis and clinical management for condition(s) mandated by their State-sponsored newborn screening programs.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	99.5	99.5	99.5	99.6	99.6
Annual Indicator	100.0	100.0	100.0	100.0	100.0
Numerator	19	20	33	37	27
Denominator	19	20	33	37	27
Data Source				Newborn Screening Blood Spot DB	Newborn Screening Blood Spot DB
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2010	**2011**	**2012**	**2013**	**2014**

Annual Performance Objective	99.6	99.6	99.6	99.8	99.8

Notes - 2009
Annual indicator continues to be 100%. Rhode Island is successful in making sure infants receive appropriate follow up.

2009: Nine infants were confirmed with Hemoglobinophathies [non sickling]. The infants did not require any treatment. Therefore, the numerator includes these 9 infants, since they did receive the appropriate follow up.

Notes - 2008
Annual indicator continues to be 100%. Rhode Island is successful in making sure infants receive appropriate follow up.

In 2008, 5 infants were confirmed with Hemoglobinophathies [non sickling]. The infants did not require any treatment. Therefore, the numerator includes these 5 infants, since they did receive the appropriate follow up.

a. Last Year's Accomplishments
Annual data shows that Rhode Island continues to maintain high levels of newborn screening and follow up. Data for 2009 shows that 100% of babies born with a positive screen received timely follow up to definitive diagnosis. A system with policies and procedures is in place to ensure that all babies receive follow up as soon as possible after a positive screen. Ensuring these high rates of follow up is a high priority for the Newborn Screening Program.

The DCFHE continued to assure early screening, diagnosis, and intervention for all newborns. Specifically, the DCFHE provided universal newborn screening for 29 conditions including hearing impairment, and developmental risks and assured that newborns identified received appropriate follow-up care.

The Newborn Screening Program continued to track all babies in need of follow-up through to a passing screen or diagnosis and initiation of treatment. This includes maintaining contracts with the RI Hearing Assessment Program at Women and Infants Hospital, VNA of Care New England for tracking and follow-up of blood spot results, and with Rhode Island Hospital for diagnosis and treatment of infants identified through bloodspot screening. The DCFHE continued to assure that newborns with developmental risks received appropriate follow-up care through the First Connections Program. In addition, culturally competent home visitors provided home visiting services to families who are difficult to reach.

A Continuous Quality Improvement (CQI) plan for bloodspot newborn screening continued. The CQI Plan included data and system level quality issues, and ongoing review by the Newborn Screening Advisory Committee of policies and procedures. The Newborn Screening Program continued to use KIDSNET to identify true missed specimens, delayed specimens, and other important systems issues which were addressed at the hospital level. Condition-specific reporting guidelines for the RI system are in development and will document reporting and follow-up processes for program staff.

Rhode Island-specific Newborn Hearing Screening process algorithms adopted from the American Academy of Pediatrics Early Hearing Detection and Intervention (EHDI) guidelines were re-printed and continue to be distributed to pediatric providers of infants needing follow-up from the newborn hearing screen. In addition, a family-friendly version was developed in English and Spanish and is now being distributed to parents of newborns needing follow-up

Upgrades were made to the newborn hearing screening database to permit bidirectional data exchange with KIDSNET of demographic information, hearing loss risk factors and audiology test results, to automatically generate follow-up correspondence in two languages, and to improve

capacity to track and report newborn hearing screening and follow-up data. On-line audiology reporting and a newborn screening report for PCPs summarizing birth information and newborn screening results and needed follow-up were implemented in KIDSNET.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Universal newborn screening, diagnosis, and intervention for 29 conditions (including hearing impairment) and developmental risk			X	
2. Newborns identified through the newborn developmental screening process are referred to First Connections Program for home visiting services		X		
3. Mechanisms to ensure that hard-to-reach families with a risk positive newborns are reached through culturally competent home visitors		X		
4. Continue planning to pre-populate the newborn screening laboratory and hearing screening databases with electronic birth certificate data				X
5. Administer a CQI plan for bloodspot screening, which includes data and systems level quality issues				X
6. Distribute integrated prenatal, perinatal, and postnatal informing brochures for providers and families			X	
7. Disseminate of the RI Early Hearing Detection and Intervention Medical Home algorithm			X	
8. Survey women who recently gave birth through PRAMS, which includes questions related to newborn screening				X
9.				
10.				

b. Current Activities

The DCFHE assures early screening, diagnosis, and intervention for all newborns through universal newborn screening for 29 inherited conditions including hearing impairment, and developmental, tracking all babies in need of follow-up. Newborns with developmental risks receive appropriate follow-up care through the First Connections Program. Electronic condition-specific reporting guidelines for the RI system are in development and will document reporting and follow-up processes for program staff via KIDSNET

Informing brochures (prenatal, perinatal, postnatal) printed in English and Spanish includes bloodspot, hearing, developmental risk, home visiting, birth defects surveillance, and KIDSNET and are distributed via maternity hospitals, mail to parents of newborns, and to obstetric offices. PRAMS continues to survey recent mothers to monitor the impact of these efforts

The newborn hearing screening database permits bidirectional data exchange with KIDSNET of demographic information, hearing loss risk factors and audiology test results to automatically generate follow-up correspondence in two languages, and to improve capacity to track and report newborn hearing screening and follow-up data. On-line audiology reporting and a newborn screening report for PCPs summarizing birth information and newborn screening results and needed follow-up are available in KIDSNET.

c. Plan for the Coming Year

The DCFHE will continue to assure early screening, diagnosis, and intervention for all newborns and will provide universal newborn screening for developmental risk and the 29 inherited conditions and hearing loss.

The NBSP will track all babies in need of follow-up through to a passing screen or diagnosis and initiation of treatment thru contracts with the RI Hearing Assessment Program at Women and Infants' Hospital for newborn hearing screening including tracking, VNA of Care New England for tracking and follow-up of blood spot results, and with Rhode Island Hospital for diagnosis and treatment of infants identified through newborn bloodspot screening, and newborns identified with developmental risks receive appropriate follow-up care through the First Connections Program. Culturally competent home visitors will provide services to families who are difficult to engage. First Connections agencies are developing outreach plans for engaging hard to reach vulnerable families and linking to medical homes.

A CQI plan for newborn screening will continue via KIDSNET to identify true missed specimens and missed hearing screens, delayed specimens and other important systems issues to be addressed at the hospital and community level. Electronic condition-specific reporting guidelines for the RI system will be implemented and will document reporting and follow-up processes for program staff via KIDSNET. Activities around Newborn Screening Long Term Follow-up, use of and retention of residual Newborn Screening Specimens as well as the recent recommendation by the Advisory Committee on Heritable Disorders in Newborns and Children to add Severe Combined Immuno-Deficiency (SCID) to the list of conditions recommended for screening, will be a major focus in the coming year.

KIDSNET will continue to pre-populate the newborn hearing screening data system with demographic data collected through the electronic birth certificate system and to exchange diagnostic audiology and risk factor information with RITrack. Training and education of KIDSNET users about the availability of this data to help assure appropriate follow-up will be conducted. Planned data system upgrades include creation of several electronic reports (annual national EHDI data report and feedback for community partners), training new user categories on KIDSNET, training audiologists on new system features, increasing access to information needed for care coordination and creating a secure mechanism to transfer electronic EHDI data among New England States with data sharing agreements.

Distribution of English and Spanish newborn services informing brochures at all maternity hospitals, obstetric provider offices, and direct mailing to parents will continue and PRAMS will survey mothers about their awareness of newborn screening.

The Rhode Island-specific Newborn Hearing Screening process algorithm will be mailed to the primary care provider of record following a confirmed diagnosis of hearing loss.

Form 6, Number and Percentage of Newborns and Others Screened, Cases Confirmed, and Treated

The newborn screening data reported on Form 6 is provided to assist the reviewer analyze NPM01.

Total Births by Occurrence:	**12230**			
Reporting Year:	**2009**			
Type of Screening Tests:	**(A) Receiving at least one**	**(B) No. of Presumptive Positive Screens**	**(C) No. Confirmed Cases (2)**	**(D) Needing Treatment**

	Screen (1)				that Received Treatment (3)	
	No.	%	No.	No.	No.	%
Phenylketonuria (Classical)	12179	99.6	0	0	0	
Congenital Hypothyroidism (Classical)	12179	99.6	167	8	7	87.5
Galactosemia (Classical)	12179	99.6	1	0	0	
Sickle Cell Disease	12179	99.6	3	3	3	100.0
Biotinidase Deficiency	12179	99.6	2	1	1	100.0
Cystic Fibrosis	12179	99.6	43	2	2	100.0
Homocystinuria	12179	99.6	68	0	0	
Maple Syrup Urine Disease	12179	99.6	30	0	0	
Congenital Adrenal Hyperplasia (CAH)	12179	99.6	159	0	0	
Hemoglobinopathies [Non Sickling]	12179	99.6	9	9	0	0.0
Metabolic Conditions	12179	99.6	217	4	4	100.0
Medium-Chain Acyl-CoA Dehydrogenase Deficiency	12179	99.6	0	0	0	

Performance Measure 02: *The percent of children with special health care needs age 0 to 18 years whose families partner in decision making at all levels and are satisfied with the services they receive. (CSHCN survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2005	2006	2007	2008	2009
Annual Performance Objective	68.6	70	70	61.4	61.4
Annual Indicator	68.6	68.6	61.4	61.4	61.4
Numerator					
Denominator					
Data Source				CSHCN survey	CSHCN survey
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	61.4	63	63	63	63

Notes - 2009

Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. The same questions were used to generate the NPM02 indicator for both the 2001 and the 2005-2006 CSHCN survey.

Data Discussion:
According to data from the 2005/2006 National Survey of Children with Special Health Care Needs (NS-CSHCN), 61.4% of families of CSHCN reported they are partners in decision making at all levels, and are satisfied with the services they receive. While this data represents a decline from the 2001 NS-CSHCN figure of 68.6%, RI remains significantly higher than the national average of 57.4%. As was discussed earlier in this application, RI's social welfare system has been under significant stress over the last several years. Difficult decisions to cut or limit eligibility to services and supports were made without much family and provider input, leaving consumers feeling disempowered.

Notes - 2008
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. The same questions were used to generate the NPM02 indicator for both the 2001 and the 2005-2006 CSHCN survey.

Data Discussion:
According to data from the 2005/2006 National Survey of Children with Special Health Care Needs (NS-CSHCN), 61.4% of families of CSHCN reported they are partners in decision making at all levels, and are satisfied with the services they receive. While this data represents a decline from the 2001 NS-CSHCN figure of 68.6%, RI remains significantly higher than the national average of 57.4%. As was discussed earlier in this application, RI's social welfare system has been under significant stress over the last several years. Difficult decisions to cut or limit eligibility to services and supports were made without much family and provider input, leaving consumers feeling disempowered.

Notes - 2007
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. The same questions were used to generate the NPM02 indicator for both the 2001 and the 2005-2006 CSHCN survey.

a. Last Year's Accomplishments
According to data from the 2005/2006 National Survey of Children with Special Health Care Needs (NS-CSHCN), 61.4% of families of CSHCN reported they are partners in decision making at all levels, and are satisfied with the services they receive. While this data represents a decline from the 2001 NS-CSHCN figure of 68.6%, RI remains significantly higher than the national average of 57.4%. In explanation of the decline, RI's social welfare system has been under significant stress over the last several years. Difficult decisions to cut or limit eligibility to services and supports were made without much family and provider input, leaving consumers feeling disempowered. More recently DCFHE through the Office of Special Health Care Needs has participated in convening stakeholders in Medicaid Reform through RI's Global Waiver Compact Demonstration.

DCFHE is committed to educating, empowering and including families at all levels of policy development and program implementation. This commitment is exemplified in the initiatives listed here and the core values of the Division that shape all programs. The Successful Start Early Childhood Systems Plan contains several elements to ensure parent engagement in policy and programming decisions related to young children, including young children with special health care needs. Parents of CSCHN, including the Executive Director of RI Family Voices, are members of the Successful Start Steering Committee.

The DCFHE through the Office of Special Healthcare Needs (OSHCN) makes resources

available to parents of children with special healthcare needs and the professionals working with them. Since FY2005, the OSHCN has made available the RI Resource Guide for Families of Children with Autism Spectrum Disorders, RI Resource Guide for Families of Children who are Deaf or Hard of Hearing, the Complete Care Notebook, and Family Voices Resource Guide. Since FY2007, the OSHCN has made available the RI Resource Guide to Mental Behavioral Services & Supports, made the RI Resource Guide for Families of Children with Autism Spectrum Disorders in Spanish and developed a toolkit for youth, parents and providers concerning adolescent healthcare transition. All of these materials are disseminated to parents and professionals to drive best practice in the diagnosis and treatment of children and youth with special health care needs within a family-centered framework.

The Pediatric Practice Enhancement Project (PPEP) was present in 24 pediatric primary and specialty practices to foster the communication and partnership between the parents and providers. Through the PPEP and Family Voices of RI, parent leaders have been cultivated and supported to lead policy initiatives, make systems improvements and champion principles of parent-professional partnerships. In FY2009, PPEP cultivated the voice of families to advocate at a policy level to address human service cuts within the RI state government.
Through the Family Voices Leadership Team, the OSHCN addressed systems barriers to a coordinated service delivery system and developed a parent policy team to provide peer-to-peer support in addressing statewide policy, especially health reform, Global Compact Medicaid Waiver and cuts to the state Medicaid program.

The Child Care Support Network offered both health/mental health consultations to child care centers staff and families. Parents of CSHCN will continue to participate on CCSN's Advisory Board. The DCFHE partners with DHS to expand the KIDS CONNECT Program to new child care centers serving CSHCN.

The Birth Defects Program continued to work with families and pediatric providers to determine whether children with birth defects are receiving appropriate services and referrals on a timely basis. Service assessment tools were developed for selected conditions and were implemented by parent consultants in several pediatric practices.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Ongoing dissemination of the Complete Care Notebook for Raising Children with Special Needs, RI Resource Guide for Families of Children who are Deaf or Hard of Hearing, and RI Resource Guide for Families of Children with Autism Spectrum		X		
2. Place trained parent consultants in pediatric primary care and specialty care settings throughout the state to assist families in navigating the system of services for CSHCN		X		
3. Provide technical assistance and information for child care providers on how to better accommodate CSHCN and behavioral challenges in child care settings		X		
4. Support the participation of parents of CSHCN in advisory and planning committees				X
5. Convene a statewide CSHCN conference on medical homes for parents of CSHCN and agencies providing services to CHSCN				X
6. Interview families of children with birth defects to determine satisfaction with services and identify barriers to and/or gaps in				X

services				
7. Collect data on medical home indicators to assess family satisfaction and decision-making				X
8. Collect information on services and referrals provided to families of children with selected birth defects via PPEP parent consultants				X
9.				
10.				

b. Current Activities

The DCFHE partners with DHS to expand the KIDS CONNECT Program to new child care centers serving CSHCN. The OSHCN continues to partner with RI Family Voices and the RI Family Voices Leadership Team to empower families and youth through education, peer-to-peer support, skill building and leadership development. OSHCN is instrumental in formulating, staffing and leading consumer voice in the implementation of the Global Compact Medicaid Waiver.

OSHCN implemented a series of patient and family-centered self-assessment inventories within the PPEP practices to assist in continuous quality improvement. Several practices are working on goals to honor families' requests, considering desired outcomes on treatment options, and ensuring that families agree with medical advise and recommendations for treatment and care. PPEP practices provided families with the following materials, "Families Partnering with Providers" and Bright Future for Families, Health Care Visit Check List for all Children including Children with Special Health Care Needs".

The results of the PPEP analysis was made available to RI stakeholders. The PPEP evaluation compared utilization rates and healthcare costs of PPEP and non-PPEP children with special healthcare needs. Evaluation results suggest that PPEP participants receive the care coordination services requested to meet their needs. Further, PPEP participants received more healthcare, yet had fewer overall healthcare costs when compared to non-PPEP users.

c. Plan for the Coming Year

The DCFHE will continue to include consumer voices (including parents of CYSHCN) in all levels of program development and implementation. The OSHCN will continue to ensure that families with CYSHCN are engaged in program planning, implementation, and evaluation and that families are full partners in the development of policy affecting their lives and the lives of their children through distribution of materials within pediatric practices, involvement in the Global Compact Medicaid Waiver Workgroups and Family Voices Policy Team. In addition, the DCFHE will continue to seek an increase in satisfaction among consumers through qualitative and quantitative evaluation of its programs and initiatives.

The OSHCN will continue to assess the need in the community for additional resource guides and distribute them to families and professionals. The OSHCN will continue to make available the RI Resource Guide for Families of Children with Autism Spectrum Disorders (in English and Spanish), the RI Resource Guide for Families of Children who are Deaf or Hard of Hearing, the RI Complete Care Notebook, the Adolescent Healthcare Toolkit, the RI Family Voices Resource Guide, and the RI Resource Guide for Behavioral Health Services and Supports.

The OSHCN will continue to promote family-centered care and parent consultant services at the through the Pediatric Practice Enhancement Project (PPEP). The PPEP will continue to work with funders, insurers and state leadership on the demonstrated impacts of the PPEP model of service delivery. The OSHCN will continue to provide technical assistance within the state and to other states regarding the engagement of consumers in all aspects of decision-making and it's importance in the health care reform debate. Through the Family Voices Leadership Team, the DCFHE will address identified systems barriers to a coordinated service delivery system.

The OSHCN will provide opportunities to demonstrate parent professional partnerships including an annual conference, policy meetings and ongoing committees.

The Birth Defects Program will continue to work with families and pediatric providers to obtain service and referral information for children with birth defects.

Performance Measure 03: *The percent of children with special health care needs age 0 to 18 who receive coordinated, ongoing, comprehensive care within a medical home. (CSHCN Survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	53.9	55.2	55.2	50.9	50.9
Annual Indicator	53.9	53.9	50.9	50.9	50.9
Numerator					
Denominator					
Data Source				CSHCN survey	CSHCN survey
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	50.9	55.5	55.5	55.5	55.5

Notes - 2009
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions and additions to the questions used to generate the NPM03 indicator for the 2005-2006 CSHCN survey. The data for the two surveys are not comparable for PM #03.

Data Discussion:
Data from the 2005/2006 National Survey of CSHCN indicate that 50.9% of CSHCN received coordinated, ongoing and comprehensive care within a medical home. While this represents a slight decline from the 2001 survey figure of 53.9%, RI's data remains well above the national average of 47.1%. As RI faces state budget constraints from a failing economy, systems of care for children and youth with special health care needs are threatened and fragmented.

Notes - 2008
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions and additions to the questions used to generate the NPM03 indicator for the 2005-2006 CSHCN survey. The data for the two surveys are not comparable for PM #03.

Data Discussion:
Data from the 2005/2006 National Survey of CSHCN indicate that 50.9% of CSHCN received coordinated, ongoing and comprehensive care within a medical home. While this represents a slight decline from the 2001 survey figure of 53.9%, RI's data remains well above the national

average of 47.1%. As RI faces state budget constraints from a failing economy, systems of care for children and youth with special health care needs are threatened and fragmented.

Notes - 2007
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions and additions to the questions used to generate the NPM03 indicator for the 2005-2006 CSHCN survey. The data for the two surveys are not comparable for PM #03.

a. Last Year's Accomplishments
Data from the 2005/2006 National Survey of CSHCN indicate that 50.9% of CSHCN received coordinated, ongoing and comprehensive care within a medical home. While this represents a slight decline from the 2001 survey figure of 53.9%, RI's data remains well above the national average of 47.1%. As RI faces state budget constraints from a failing economy, systems of care for children and youth with special health care needs are threatened and requires constant advocacy to preserve. In this environment, it is not uncommon for providers of critical home and community and medical home services to engage families in their advocacy efforts.

The DCFHE supports the elements of a medical home through all of the maternal and child health programs, including the Office of Special Health Care Needs, Preventative Services, Early Childhood Programs, Women's Health and Adolescent Programs; in addition to programs addressing Chronic Disease Management, Primary Care, Minority Health, and Health Promotion and Wellness. As Successful Start implemented its statewide Early Childhood Systems Plan, several initiatives to build the capacity of medical homes are underway. In partnership with the RI Chapter of the American Academy of Pediatrics, a workgroup created a model of developmental screening and referral to services. The DCFHE worked to increase the number of CSHCN in RI who have a medical home by partnering with PPEP, DHS (on CEDARR, EPSDT, and Medicaid policy), Health Plans, the RI Chapter of the American Academy of Pediatrics, and the Society of Adolescent Medicine.

The PPEP -- medical home enhancement project -- expanded to include several community based organizations and specialty service providers. The Family Voices Leadership Team addressed barriers identified through the PPEP to a coordinated service delivery system and partnered with health plans to identify and reimburse medical home-type services. The DCFHE worked with RI health plans on appropriately reimbursing practices that provide a comprehensive medical home.

The OSHCN participated on the CEDARR Interdepartmental Team, convening RI's Leadership Roundtable on CSHCN addressing care coordination and additions to the Medicaid package, was engaged in distributing RI's EPSDT Schedule, supported existing medical home systems development in the communities of Newport, Washington County, Mt. Hope, and Pawtucket/Central Falls. The DCFHE continued to provide assistance and support to the AAP/CATCH medical home projects in Woonsocket, Washington County and the Providence neighborhood of Mount Hope.

First Connections Home Visiting linked children at risk for developmental concerns to a medical home and provided education / support to families. PPEP parent consultants in the Neonatal Intensive Care Unit at Woman & Infants Hospital, the Ventilator Integration Program at Hasbro Children's Hospital and the Neonatal Follow-Up Program provided medical home services to infants and toddlers with complex medical conditions.

Successful Start is piloting a model of developmental screening and referral to services. Youth Consultants conducted research to develop a teen medical home model, indicators and utilization info. The DCFHE worked with the Center for Health Data and Analysis to determined the percent of RI children with medical homes. The Birth Defects Program collected and analyzed data from multiple sources including hospitals, KIDSNET, pediatric practices and families to determine

whether children with birth defects have a medical home.

The DCFHE Adolescent Health Program, through a partnership with the Northern RI Area Health Education Center and the Woonsocket CATCH grant coalition, produced a report on medical homes for adolescents in Woonsocket.

The Office of Primary Care & Rural Health (OPCRH) made mini-grants to ten community partners to improve and expand primary care and Patient Centered Medical Homes in rural/non-metro areas of the state, through support for local Maternal & Child Health needs assessment, strategic planning and project implementation. The OPCRH conducted a survey of primary care physicians statewide, to identify areas of under service and gather information on access to culturally responsive primary care based on medical home principles.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Expand the Pediatric Practice Enhancement Project to new pediatric primary and specialty care offices serving CSHCN		X		
2. Continue efforts to build the infrastructure necessary to sustain the model of parent consultants in pediatric offices				X
3. Outreach to and enroll pediatric providers in KIDSNET to ensure that all children, including CSHCN, have a medical home and are linked to appropriate support services				X
4. Through the First Connections, continue to link children to medical homes and provide parent education and family support to vulnerable children and families		X		
5. Support systems development efforts that work to build medical home capacity in local communities				X
6. Finalize a model of early childhood developmental screening and services and pilot the model in selected communities in the state			X	
7. Continue work to assure that children with birth defects have a medical home and receive appropriate services			X	
8. Continue collaborative work with DHS, RI Family Voices, professional associations, and other stakeholders to build medical homes for CSHCN				X
9. Analyze indicators of a medical homes to determine the percentage of RI children who have a medical home				X
10. Develop models of adolescent medical homes aligned with existing investments and provide assistance to community based AAP/CATCH medical home project				X

b. Current Activities

DCFHE works to increase the number of CYSHCN in RI who have a medical home. PPEP's evaluation analyzed the short / long term health outcomes and proved the PPEP model to be a cost-effective system of care coordination and work is underway to include PPEP in RI's Medicaid Reform efforts. The OSHCN and its partners administer the Peer Assisted Health Initiative (PAHI) in 10 primary and specialty care practices. OSHCN implemented a series of self-assessment inventories within the PPEP and PAHI practices for continuous quality improvement.

The OSHCN collaborates with Family Voices Leadership; participates on the CEDARR Interdepartmental Team overseeing RI's care coordination system for CYSHCN and assists in leading the RI's Leadership Roundtable Team to address the systems barriers to a coordinated

service delivery system.

The DCFHE participated in a community stakeholder forum with the Woonsocket CATCH grant partners to identify and plan local priorities for adolescent medical homes in Woonsocket and also supported the Washington County CATCH community assessment efforts around teen pregnancy, delayed prenatal care, and food insecurity in Westerly, and medical home efforts in the Mt. Hope neighborhood of Providence.

The OPCRH developed standards for RI Patient centered Medical Homes and worked with community partners to identify several common MCH needs among rural/non-metro areas of the state including teen pregnancy rates and lack of behavioral health access.

c. Plan for the Coming Year

The DCFHE will continue to work to increase the number of CYSHCN in RI who have a comprehensive medical home. To accomplish this, the DCFHE will improve and expand its current programming as well as partner with state and community agencies, including DHS (on CEDARR and other initiatives), the RI Chapter of the American Academy of Pediatrics, and the Society of Adolescent Medicine. DCFHE will ork with the Center for Health Data and Analysis to determine the proportion of CSHCN in RI who have a medical home.

The OSHCN will continue to promote access to a medical home through the PPEP. The plan for the PPEP is to access public and private insurance reimbursement for purposes of sustainability and to continue program evaluation. The OSHCN will be partnering with RI's Medicaid Managed Care Plans, Area Health Education Centers and the RI Health Commissioner's Office on positioning the PPEP model within the healthcare reform and raising the awareness among RI's practitioners of medical home concepts and practices. The OSHCN will continue to enhance medical homes for young adults through the PAHI.

The Family Voices Leadership Team will continue to partner with health plans to identify and reimburse medical home-type services and to address the systems barriers to a coordinated service delivery system.

The OSHCN will continue to participate on the CEDARR Interdepartmental Team to address care coordination for CYSHCN, additions to the Medicaid package, and support for medical home through the EPSDT Schedule.

DCFHE will continue to provide technical assistance and tools on medical homes the Woonsocket CATCH, Washington County CATCH and Mount Hope CATCH as well as identify and assist additional communities to secure CATCH funding to support medical home projects.

The OPCRH will offer Rural Health Systems Building Grants to coalitions/networks in each of the four non-metro areas of the state, to expand and enhance systems of care including strengthening partnerships between health care providers and community-based supports. The OPCRH will conduct analyses of primary care physician shortages and submit updates as needed to maintain federal Health Professional Shortage Area designations in RI, and eligibility for federal support through the Community Health Center and National Health Services Corps programs.

DCFHE will build capacity for quality asthma education and home assessment of children with severe asthma. The RI Asthma Control Program will partner with Hasbro Children's Hospital on a pilot project that will help build capacity and provide data to support the cost-effectiveness of asthma services and supplies that will increase self-management of asthma among children with asthma and their parents, and address environmental triggers in the home.

DCFHE will add all six questions from the BRFSS Child Selection Module in 2011to better evaluate BRFSS data regarding children with special health care needs, the RI

Performance Measure 04: *The percent of children with special health care needs age 0 to 18 whose families have adequate private and/or public insurance to pay for the services they need. (CSHCN Survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	68.9	70.2	70.2	68.2	68.2
Annual Indicator	68.9	68.9	68.2	68.2	68.2
Numerator					
Denominator					
Data Source				CSHCN survey	CSHCN survey
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	68.5	70.2	70.2	70.2	70.2

Notes - 2009
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. The same questions were used to generate the NPM04 indicator for both the 2001 and the 2005-2006 CSHCN survey.

Data Discussion:
Data from the 2005/2006 National Survey of CSHCN indicates that 68.1% of families with CSHCN have adequate private and/or public insurance to pay for the services they need. This percentage is largely consistent with the 2001 National Survey results of 68.9%. RI has a high rate of insured children as a result of the state's collective commitment to the RIteCare Program. This performance measure reminds RI that insurance status alone does not mean that families can pay for all the services they need.

Notes - 2008
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. The same questions were used to generate the NPM04 indicator for both the 2001 and the 2005-2006 CSHCN survey.

Data Discussion:
Data from the 2005/2006 National Survey of CSHCN indicates that 68.1% of families with CSHCN have adequate private and/or public insurance to pay for the services they need. This percentage is largely consistent with the 2001 National Survey results of 68.9%. RI has a high rate of insured children as a result of the state's collective commitment to the RIteCare Program. This performance measure reminds RI that insurance status alone does not mean that families can pay for all the services they need.

Notes - 2007

Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. The same questions were used to generate the NPM04 indicator for both the 2001 and the 2005-2006 CSHCN survey.

a. Last Year's Accomplishments
Data from the 2005/2006 National Survey of CSHCN indicates that 68.1% of families with CSHCN have adequate private and/or public insurance to pay for the services they need. This percentage is largely consistent with the 2001 National Survey results of 68.9%. RI has a high rate of insured children as a result of the state's collective commitment to the RIte Care Program. This performance measure reminds RI that insurance status alone does not mean that families can pay for all the services they need. .

The Department of Health worked with the Office of the Health Insurance Commissioner to review the state's private insurance package to ensure it includes services families need. The OSHCN worked collaboratively with the state's Medicaid office to enhance the EPSDT benefit and availability of services. The DCFHE continued to work to increase the percentage of CSHCN with adequate insurance to pay for the services they need.

The Pediatric Practice Enhancement Project (PPEP) assisted 4000 families with CYSHCN in 2009 on issues concerning insurance, education, and access to mental health services. Almost 25% of these families required direct assistance in accessing insurance. The First Connections Program continued to identify families with no or inadequate health insurance and refer them to appropriate programs and services, including FRCs, Medicaid, SSI, and Katie Beckett.

The DCFHE supported the toll-free Family Health Information Line, which continued to refer families to appropriate resources, including Medicaid/RIte Care. The Family Health Information Line is a statewide resource for all families, including those with CSHCN, and is staffed by bi-lingual information specialists. Culturally appropriate informational materials for families were distributed through the centralized distribution center.

DCFHE staff continued to participate in the RIte Care Consumer Advisory Committee. This committee is convened monthly by DHS and is charged with ensuring that RIte Care families' needs are at the center of program decision-making.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Assist in efforts to transition CHSCN to Medicaid managed care and provide appropriate, comprehensive, and coordinated services through managed care mechanisms				X
2. Continue to support the Pediatric Practice Enhancement Project, which links families to Medical Assistance and includes a strong service coordination component to assist families of CSHCN in accessing services		X		
3. Support the First Connections Program in referring families with no or inadequate health insurance to Medical Assistance and in linking families to community-based health and social services		X		
4. Participate on the CEDARR Interdepartmental Team which oversees and monitors the state’s care coordination system for CSHCN				X
5. Distribute and evaluate the Complete Care Notebook for Raising CSHCN and other CHSCN resource guides		X		

6. Participate on the Rhode Island Pediatric Council, the RIte Care Consumer Advisory Committee, and other groups which advocate for appropriate and accessible services for CSHCN				X
7.				
8.				
9.				
10.				

b. Current Activities
HEALTH works with the Office of the Health Insurance Commissioner to ensure the state's private insurance providers fund necessary services. The OSHCN works collaboratively with the state's Medicaid office to enhance the EPSDT benefit. The OSHCN is working with the Joint Commission for Educating Children with Autism Spectrum Disorders to pass private insurance mandated coverage for the identification and treatment of children with ASD in RI.

PPEP and PAHI screens / enrolls eligible families into Medicaid, SSI and Katie Beckett across the state. The OSHCN works with community partners, advocacy organizations and local providers to increase access to care and address barriers to enrollment.

The First Connections Program refers vulnerable families with no or inadequate health insurance to appropriate services and programs. The toll-free Family Health Information Line links callers to health insurance options.

The Complete Care Notebook enables families to track expenses and determine adequacy of insurance. The DCFHE distributes and evaluates the use of condition-specific resource guides which detail financing options for families raising CYSHCN and works to ensure accurate information concerning federal health care reform for community providers and consumers.

DCFHE participates on the CEDARR Interdepartmental Team RI Pediatric Council, the RIte Care Consumer Advisory Committee, the Family Voices Leadership Team, and the Neighborhood Health Plan.

c. Plan for the Coming Year
The DCFHE will continue to work to increase the percentage of CSHCN, ages 0-18, whose families have adequate private and/or public insurance to pay for the services they need.

PPEP will continue to ensure that families with CSHCN, from birth to twenty-one years of age, are linked to adequate health financing programs, including Medicaid, SSI, and Katie Beckett. The OSHCN will continue to work on private insurance legislation in support of children and youth with an ASD.

In FY2011, the Family Outreach Program will continue to refer vulnerable families with no or inadequate health insurance to appropriate services and programs. The toll-free Family Health Information Line will continue to provide information to callers about health insurance options, including Medicaid/RIte Care.

The DCFHE will continue to participate on the CEDARR Interdepartmental Team. The Team will continue to be responsible for program monitoring and oversight, policy review and revision, and program development. CEDARR includes a strong care coordination component, which ensures that families with CSHCN are linked to financial resources for which they may be eligible.

The DCFHE will outreach to families on the use of the Complete Care Notebook to track expenses and determine adequacy of insurance. The DCFHE will continue to distribute and evaluate the use of condition-specific resource guides. These guides detail financing options for

families raising CSHCN.

DCFHE staff will continue to participate on the Rhode Island Pediatric Council, the RIte Care Consumer Advisory Committee, the Family Voices Leadership Team, and the Neighborhood Health Plan CSHCN Advisory Board to ensure that health care for CSHCN is accessible, adequately financed, culturally competent, and family-centered.

Performance Measure 05: *Percent of children with special health care needs age 0 to 18 whose families report the community-based service systems are organized so they can use them easily. (CSHCN Survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	78.8	80	80	87.6	87.6
Annual Indicator	78.8	78.8	87.6	87.6	87.6
Numerator					
Denominator					
Data Source				CSHCN survey	CSHCN survey
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	87.6	80	80	80	80

Notes - 2009
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN survey, there were revisions to the wording, ordering and the number of the questions used to generate the NPM05 indicator for the 2005-2006 CSHCN survey. The data for the two surveys are not comparable for PM #05.

Data Discussion:
According to the 2005/2006 National Survey of CSHCN, 87.6% of families of CSHCN reported that services are organized in ways they can be easily used. While this represents an 11.2% increase from the 2001 figure of 78.8%, RI remains lower than the national average of 89.1%. Over the past several years, RI state government has undergone a consolidation and reorganization process and developed a few key points of entry into the system. More attention to informing families of these centralized resources is required for RI to improve on this measure.

Notes - 2008
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN survey, there were revisions to the wording, ordering and the number of the questions used to generate the NPM05 indicator for the 2005-2006 CSHCN survey. The data for the two surveys are not comparable for PM #05.

Data Discussion:
According to the 2005/2006 National Survey of CSHCN, 87.6% of families of CSHCN reported that services are organized in ways they can be easily used. While this represents an 11.2%

increase from the 2001 figure of 78.8%, RI remains lower than the national average of 89.1%. Over the past several years, RI state government has undergone a consolidation and reorganization process and developed a few key points of entry into the system. More attention to informing families of these centralized resources is required for RI to improve on this measure.

Notes - 2007
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN survey, there were revisions to the wording, ordering and the number of the questions used to generate the NPM05 indicator for the 2005-2006 CSHCN survey. The data for the two surveys are not comparable for PM #05.

a. Last Year's Accomplishments
According to the 2005/2006 National Survey of CSHCN, 87.6% of families of CSHCN reported that services are organized in ways they can be easily used. While this represents an 11.2% increase from the 2001 figure of 78.8%, RI remains lower than the national average of 89.1%. Over the past several years, RI state government has undergone a consolidation and reorganization process and developed a few key points of entry into the system. More attention to informing families of these centralized resources is required for RI to improve on this measure.

In Rhode Island, as in other parts of the country, services for families can often be fragmented and hard to navigate. The DCFHE worked both at the state and community levels to create new procedures and pathways to enable CYSHCN and their families to more easily navigate existing health and social service systems. Through consolidation of health and human service agencies, RI is addressing fragmented services and points of entry into social services, especially CYSHCN and their families. The OSHCN is committed to assisting families in navigating the special needs service delivery system as this was one of the goals of the PPEP and the development of several resource guides.

The DCFHE continued to build the Pediatric Practice Enhancement Project (PPEP), which assists families of CSHCN in accessing medical and community services. Services were expanded to several new sites. In addition, PPEP parent consultants participated in several quality assurance meetings with the CEDARR Interdepartmental Team and the CEDARR Family Centers in order to enhance collaboration, reduce duplication, and clarify roles. These meetings led to policy changes in the CEDARR Program regarding access and service provision. PPEP parent consultants were instrumental in training the central points of entry within the Executive Office of Health and Human Services (OHHS).

The DCFHE continued its participation in the implementation and ongoing quality assurance activities for CEDARR, the state's care coordination system for CYSHCN and the implementation of the Global Medicaid Waiver. OSHCN staff contributed to program oversight and quality improvement through the CEDARR Interdepartmental Team.

The OSHCN disseminated the Complete Care Notebook for Raising CSHCN. The Notebook was developed in response to requests from families for a portable organizer to record and file their child's important health information. The Notebook also includes a community and state resource guide. The Notebook was distributed to families through the Women & Infants Hospital NICU, Hasbro Children's Hospital Children's Neurodevelopment Center, and Early Intervention providers.

The DCFHE's Successful Start, RI's State Early Childhood Comprehensive Systems Initiative is working to improve and coordinate the state's systems of early childhood services, with a special focus on systems serving CSHCN. Successful Start continued implementing the Successful Start Early Childhood Systems Plan, incorporating numerous strategies to streamline services, facilitate relationship building between providers, and promote parent engagement and family-centered.

Since FY2006, several communities began or continued systems building initiatives focused on the health care needs of children, including CSHCN. The DCFHE supported these initiatives by providing technical assistance on community organizing, executing a needs assessment, and developing a strategic plan. The DCFHE also provided community-level data to these groups as they worked to identify needs and resources to meet those needs. DCFHE continues to work with the Woonsocket CATCH, Newport County Healthy Communities Initiative, the Washington County Coalition for Children, and the Mt Hope CATCH to improve medical homes.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Pilot a community-based model of developmental screening and services to ensure that children at-risk for delays and disabilities are identified and access appropriate intervention services			X	
2. Provide support and technical assistance to community systems development initiatives, including CATCH projects and child and family coalitions				X
3. Continue expansion of PPEP to additional sites to assist families of CSCHN in accessing community-based services and supports		X		
4. Distribute and evaluate the Complete Care Notebook for Raising Children with Special Needs and other resource guides for families of CSHCN		X		
5. Continue to obtain service and referral information from families of children with birth defects via the Birth Defects Program and PPEP parent consultants.				X
6. Provide oversight to and ensure the continuous quality improvement of the CEDARR program through the CEDARR Interdepartmental Team				X
7. Continue to support the Family Voices Leadership Team in its efforts to ensure a comprehensive coordinated service delivery system for CSHCN				X
8. Convene a Successful Start transitions group to develop comprehensive systems of care for children 9years and older				X
9.				
10.				

b. Current Activities

Rhode Island is addressing the ease of navigating service systems for families of CYSHCN through integration initiatives within the DCFHE and the OHHS and work at the state and community levels. The DCFHE and the OHHS work on a Modernization Initiative that streamlines the application process for Medicaid.

The OSHCN is committed to assisting families in navigating the special needs service delivery system. Parent / peer consultants collect data on system barriers & assist families in accessing resources. These concerns are addressed by the Family Voices Leadership Team, state and community leaders. The OSHCN provides families with resources to ease in system navigation.

Successful Start and RI AAP are increasing the dev screening/services to young children via community-based dev screening/referral services in childcare centers and medical homes.

DCFHE provides technical assistance to Woonsocket CATCH's adolescent medical home

project, Washington County CATCH's teen pregnancy, delayed prenatal care, and food insecurity project, and Mt Hope CATCH's efforts to improve community linkages to MCH services. The Child Care Support Network-partners with Washington County Coalition on health/mental health consultation in child care settings.

The Birth Defects Program continued to assess services and referrals provided to families of children with birth defects.

c. Plan for the Coming Year

The OSHCN will continue to administer the PPEP and PAHI; work with the EOHHS, the Medicaid agency, the CEDARR program, and the Global Compact Medicaid Waiver Workgroups on a coordinated system of care for CYSHCN and their families. The OSHCN will continue to print, distribute, and evaluate the Complete Care Notebook for Raising Children with Special Needs, the Resource Guide for Families of Children Who are Deaf or Heard of Hearing, the Resource Guide for Families of Children with Autism Spectrum Disorders (in English and Spanish), and the RI Resource Guide for Families of Children with Mental / Behavioral Health Conditions.

The Birth Defects Program will continue to assess service / referrals to families of children with birth defects and related issues as well as continue to support streamlining the service delivery system for CYSHCN and its partnerships with state /community partners to ensure coordination between programs & services.

Successful Start will continue to support the developmental screening and services in several communities with interested primary care providers. A new transition workgroup will be convened to discuss the development of comprehensive systems of support for children ages 9 years and older.

DCFHE will continue to participate in and provide technical assistance to existing and emerging community systems development initiatives, including CATCH projects and child and family coalitions throughout the state. This will include continuing to provide technical assistance and tools on medical homes to Woonsocket CATCH, Washington County CATCH, and Mt Hope CATCH .. DCFHE will identify and assist additional communities to secure CATCH funding to support medical home projects..

The Child Care Support Network will continue partnering with the Washington County Coalition to offer health and mental health consultation in childcare settings.

DCFHE will collaborate with DHS, Neighborhood Health Plan of RI, Family Voices RI, and the RI Parent Information Network to identify and alleviate the barriers of coordinating care for CYSHCN. Parent consultants will continue to assist medical homes in developing linkages with community resources and assist families in accessing those resources.

Performance Measure 06: *The percentage of youth with special health care needs who received the services necessary to make transitions to all aspects of adult life, including adult health care, work, and independence.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2005	2006	2007	2008	2009
Annual Performance Objective	5.8	6.4	6.4	37.6	37.6
Annual Indicator	5.8	5.8	37.6	37.6	37.6
Numerator					

Denominator					
Data Source				CSHCN survey	CSHCN survey
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	37.6	38.4	38.4	38.4	38.4

Notes - 2009
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate the NPM06 indicator for the 2005-2006 CSHCN survey. There were also issues around the reliability of the 2001 data because of the sample size. The data for the two surveys are not comparable for PM #06 and the 2005-2006 may be considered baseline data.

Data Discussion:
According to the NS-CSHCN, youth with SHCN who received the services necessary to make appropriate transitions to adult health care, work and independence was 37.6% in 2005/2006. RI's percentage remains lower than the national average of 41.2%. Increasing the successful transition from pediatric to adult healthcare has been identified by the DCFHE as a primary objective.

Notes - 2008
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate the NPM06 indicator for the 2005-2006 CSHCN survey. There were also issues around the reliability of the 2001 data because of the sample size. The data for the two surveys are not comparable for PM #06 and the 2005-2006 may be considered baseline data.

Data Discussion:
According to the NS-CSHCN, youth with SHCN who received the services necessary to make appropriate transitions to adult health care, work and independence was 37.6% in 2005/2006. RI's percentage remains lower than the national average of 41.2%. Increasing the successful transition from pediatric to adult healthcare has been identified by the DCFHE as a primary objective.

Notes - 2007
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate the NPM06 indicator for the 2005-2006 CSHCN survey. There were also issues around the reliability of the 2001 data because of the sample size. The data for the two surveys are not comparable for PM #06 and the 2005-2006 may be considered baseline data.

a. Last Year's Accomplishments
According to the NS-CSHCN, youth with SHCN who received the services necessary to make appropriate transitions to adult health care, work and independence was 37.6% in 2005/2006. RI's percentage remains lower than the national average of 41.2%. Increasing the successful

transition from pediatric to adult healthcare has been identified by the DCFHE as a primary objective. A coordinated approach between an all-youth and youth with special health care needs agenda has been developed.

The DCFHE developed a strategic plan to address all transitions from pediatric to adult health care by strengthening efforts on adolescent medical home. The OSHCN identified transition of youth with special health care needs as a priority. The OSHCN, in collaboration with the RI Chapter of the American Academy of Pediatrics, developed and administered a survey to all licensed practicing primary care pediatricians in Rhode Island in order to further understand the health care transition process from the perspective of physicians. The findings of the survey were analyzed to develop outreach, training, and education strategies for youth, families, and health care professionals.

Pediatric Practice Enhancement Project (PPEP) participating sites have been working on identifying YSHCN in need of transition support. In FY2009, the OSHCN made presentations of the adolescent healthcare transition toolkit to physician, family, advocacy, legislative, and education groups on the importance of healthcare transition.

The DCFHE worked with the adult and pediatric rehabilitation units at RI Hospital to facilitate a seamless transition to adult rehabilitative care. The DCFHE sponsored an interactive session at the FY09 Parent / Professional Partnership meeting where national and local transition specialists brought awareness to issues concerning transition.

The OSHCN worked closely with DHS in the implementation and evaluation of the CEDARR Initiative and the transitioning of CSHCN from fee-for-service Medicaid to Medicaid managed care. The OSHCN ensured that YSHCN in Medicaid Managed Care were provided assistance in transitioning from pediatric to adult medicine.

The DCFHE continued to participate on the RI Transition Council comprised of state departments and family members that provides technical assistance to the state's regional transition centers and monitors the transition system. As a member of the RI Transition Council, the OSHCN collaborated on developing RI's Secondary Transition IEP to include components of health care as it relates to educational / vocational / employment pursuits.

The OSHCN was also successful in addressing transition planning on the State's EPSDT Schedule.

In collaboration with RIDE, the DCFHE participated in a 3-year evaluation study of students who have graduated from high school to determine the effectiveness of CYSHCN services.

The DCFHE produced and disseminate an annual Disability Data Book on individuals with disabilities, including CYSHCN who are transitioning to adulthood. The OSHCN included a disability indicator on the 2009 iteration of the Youth Behavior Risk Survey. When comparing youth with a special need and youth without a special need, several areas of risk were uncovered. Students with disabilities are more likely to smoke cigarettes, drink alcohol, and use marijuana before the age of 13. They are also more likely to continue these risky behaviors by currently smoking cigarettes, drinking alcohol, and using marijuana. Students with disabilities are more likely to report feelings of hopelessness and to consider and attempt suicide. Students with disabilities are more likely to be threatened, physically fight, be forced to have sex, and not go to school due to feeling unsafe. Students with disabilities are also more likely to be overweight.

In May 2009, the OSHCN and the Transition Council sponsored the first youth with special needs leadership conference, Dare 2 Dream. Over 300 students attended the event intended to motivate and inspire youth with disabilities to follow their dreams, find their voice in self-advocacy and take the necessary steps to accomplishment.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Support the Children's Neurodevelopment Center and PPEP, both of which serve CSHCN transitioning to adult health care systems		X		
2. Continue to participate on the Rhodes To Independence Youth In Transition Subcommittee				X
3. Continue to participate on the Rhode Island Transition Council				X
4. Continue to efforts to improve the transition process through provider surveys and by fostering collaborations between pediatric and adult providers				X
5. Continue to use the Complete Care Notebook as a model of a medical summary that can flow from the pediatric to adult provider at the time of transition		X		
6. Provide support and assistance to DHS in administering the CEDARR Initiative				X
7. Provide support and assistance to DHS and Neighborhood Health Plan of RI in transitioning CSHCN to Medicaid managed care and providing appropriate services to this population				X
8. Produce and disseminate publications including data on individuals with disabilities and CSHCN transitioning to adulthood			X	
9.				
10.				

b. Current Activities

The DCFHE is addressing adolescent transition through strengthening the medical home for all adolescents.

The OSHCN, the RI AAP, Rhodes to Independence and Healthy and Ready to Work are conducting a statewide needs assessment of health care providers regarding the transition process and to identify their capacity to accept transitioning youth with disabilities and chronic health conditions); family / youth outreach and education and healthcare provider resources. The OSHCN developed and actively disseminates a youth / parent self-assessment series entitled "Ready? Set… Go!" used to encourage independence, personal responsibility, principles of self-determination, and adolescent development.

PPEP sites are implementing the adolescent healthcare toolkit and the Physician Checklist. A parent consultant and youth consultant assist in coordinating transition activities/materials development. The OSHCN is partnering with the Adolescent Leadership Council, the MedPeds Clinic at Rhode Island Hospital and the Hasbro Children's Hospital on a Transition Clinic to ensure youth have a transition plan. The OSHCN is working with the RI AAP and the Hasbro Children's Hospital on defining the EPSDT requirement for transition planning including principles, products, and procedure codes.

In May 2010, the OSHCN and the Transition Council sponsored the second youth with special needs leadership conference, Dare 2 Dream reaching over 500 students.

c. Plan for the Coming Year

The DCFHE will continue to prioritize the transitioning from pediatric to adult health care, work, and independence.

The OSHCN plans to partner with the Transition Council, PPEP, and TALC addressing and sponsoring activities concerning the health and wellness of young adults with disabilities and chronic conditions. The educational component of the health and wellness activities will explore responsibility, decision-making, healthy lifestyles, and reducing secondary conditions. The physical activity component will involve activities such as volleyball, kayaking, bowling, and cycling.

The DCFHE will continue to make the adolescent healthcare toolkit available to youth, parents and physicians and provide technical assistance as indicated. The DCFHE will continue to participate on the Rhodes To Independence, Youth In Transition Subcommittee, the RI Transition Council and the Adolescent Leadership Council. The OSHCN plans to expand the scope and reach of the Dare 2 Dream Student Leadership Conference and to develop a Youth Advisory Committee.

The DFCHE will continue to work to include OSHA standards in worksites and collaborate with the RI Department of Labor and Training on rights for teen workers.

Performance Measure 07: *Percent of 19 to 35 month olds who have received full schedule of age appropriate immunizations against Measles, Mumps, Rubella, Polio, Diphtheria, Tetanus, Pertussis, Haemophilus Influenza, and Hepatitis B.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	86.5	86.5	80.5	84.5	80.9
Annual Indicator	83.1	82.2	80.0	79.5	82.6
Numerator	10968	10504	10152	9834	10218
Denominator	13199	12778	12690	12370	12371
Data Source				National Immunization Survey	National Immunization Survey
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	84.9	85	85.2	85.5	85.7

Notes - 2009
Rhode Island's coverage rate for the 4:3:1:3:3:1 series was enormously impacted by the HIB shortage, which started in December 2007. Therefore the 2009 data reported are from National Immunization Survey's 4:3:1:_:3:1 . The Varicella vaccine was added to the complete series. The coverage rate meets the Healthy People 2010 target for the PM at 80%.

Denominator is estimated based on number of resident births that occurred two years prior.

Notes - 2008
Data for 2008 are estmated. According to the 2008 NIS data, 79.5% were vaccinated, which was very similar to the coverage rate of 80.0% for 2007. The coverage rates declined significantly when comparing to 2004, but Rhode Island still meets the Healthy People 2010 target for the PM at 80%.

Data for this performance measure reflects the 4:3:1:3:3 series collected through the National Immunization Survey. Denominator is estimated based on number of resident births that occurred two years prior.
Children in the 2008 NIS were born between January 2005 and June 2007.

Notes - 2007
Data for 2007 are estmated.

Data for this performance measure reflects the 4:3:1:3:3 series collected through the National Immunization Survey.
Denominator is estimated based on number of resident births that occurred two years prior.

a. Last Year's Accomplishments
According to 2008 National Immunization Survey data, vaccination coverage rates among children 19-35 months of age in Rhode Island who have received the full schedule of age appropriate immunizations against Measles, Mumps, Rubella, Polio, Diphtheria, Tetanus, Pertussis, Haemophilus Influenza, and Hepatitis B exceeded national levels and achieved the HP 2010 goal of 80%. With the exception of DTaP (88 %) and Hib (89%) vaccines, Rhode Island's estimated coverage for each individual vaccine series increased or remained constant at greater than 90% also exceeding the HP 2010 goals. Partnerships between public health, community practices, and parents are working. The universal vaccine policy, vigorous use of KIDSNET to support immunization, outreach in childcare and community settings, and the strong support of professionals throughout the state, has kept us in the top tier of states.

The DCFHE continued to provide all recommended vaccines to providers, free immunizations to uninsured children, and immunization education to providers and the public. The DCFHE focused its improvement rates on populations new to the country and state through it's support of the St. Joseph's Free Immunization Clinic and served 3,272 mostly uninsured and immigrant children. The DCFHE continued to offer injectable and intranasal influenza vaccine for children ages six months through 18 years.

In FY2009, the DCFHE continued its assessment of immunization rates of children receiving care through home childcare providers. Four evening trainings were held in the fall to update childcare providers on immunization requirements and offered help in filling out the immunization survey as well as inform and educate providers about H1N1 prevention. A partnership was formed with the Department of Children, Youth, and Families to offer incentive credit for all licensed providers that attended the trainings.

During the 2009/2010 school year, DCFHE staff visited and assessed immunization records in 65 schools that hold kindergarten and 65 schools that hold 7th grade students. Up to twenty immunization records in each grade were reviewed. DCFHE organized statewide successful school based H1N1 vaccine clinics. Children with chronic health conditions were immunized early on in this effort.

The DCFHE distributed a newly designed immunization requirement manual to childcare centers, in-home day cares, Head Start agencies, and schools. The manual outlined mandatory vaccination requirements and offered tools and guidelines for assessing vaccination status of

children in school settings. The DCFHE created educational materials for providers and patients on new childhood vaccines (meningococcal conjugate and pertussis booster).

The Immunization Program worked with the Education Coordinators at all of the state's birthing hospitals to distribute culturally appropriate Health and Safety Records in the hospital discharge packages. The DCFHE also met with Nurses from the seven birthing hospitals around the state to organize the implementation of standing orders to provide post-partum women with a Tdap vaccination prior to discharge to protect their newborns from pertussis.

The DCFHE utilized the Newborn Developmental Risk Assessment Screening to capture maternal Hepatitis B information and newborn Hepatitis B vaccination and treatment information stored in KIDSNET. Infants born to Hepatitis B positive mothers were referred to the Perinatal Hepatitis B Program for case management, to ensure completion of the Hepatitis B vaccination series. In 2009 all 45 babies born to HBsAg-positive women received HBIG and Hepatitis B vaccine within 24 hours of birth.

The Newborn Developmental Risk Assessment Screening Program and KIDSNET continued to capture and store maternal Hepatitis B information. KIDSNET released a guide for HL7 immunization transactions to submit electronic immunization data to KIDSNET in standard format. The HL7 data exchange was successfully tested with one community health center and one electronic medical record.

The WIC Program assessed the immunization status of children receiving WIC services based on DTaP at certification appointments. Referrals, by a nutritionist to the provider, are made for those clients who appear not up to date. The Child Care Support Network continued to provide immunization informational materials to families accessing center and home-based child care services.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Provide all recommended vaccines for all children in Rhode Island, including influenza vaccine during influenza season, for all children ages 6 months through 18 years			X	
2. Provide free immunizations to uninsured and newly emigrated children	X			
3. Revise and distribute culturally and linguistically appropriate immunization materials to families, health care providers, child care providers, and schools throughout the state			X	
4. Continue to update the Immunization Program website to include specific sections for health care professionals, child care providers, school personnel, and culturally diverse families			X	
5. Host a biannual conference for school nurse teachers to provide up-to-date information on a variety of health care issues, including immunizations		X		
6. KIDSNET will continue to track children's immunization status				X
7. Continue to enroll new pediatric and other providers of services to children and families in KIDSNET				
8. Provide technical assistance, consultation, and resource materials to child care providers to ensure that all children in child care are up-to-date on their immunizations			X	
9. Provide Tdap vaccine to birthing hospital to vaccinate post-partum women prior to discharge	X			

10.				

b. Current Activities
The DCFHE provides all ACIP recommended vaccines to providers, free immunizations to uninsured children, and education materials to providers / public ensuring children receive immunizations. Vaccine is delivered directly to provider offices.

KIDSNET tracks the immunization status of children who receive state supplied vaccine. Providers may generate reports on their patients' immunization status and exchange information with managed care organizations.

The Child Care Support Network offers health consultation to childcare centers/ family childcare homes. Nurses review child health records (including immunization status), provide staff training and preventative health/safety TA, distribute educational materials, and refer families to community services and resources. EI sites are being connected to KIDSNET. WIC sites view KIDSNET to access children's immunization status. KIDSNET captures Newborn developmental risk screening and stores maternal Hepatitis B information.

The Chronic Care and Disease Management programs including the Diabetes Program in its quality improvement work through the RI Chronic Care Collaborative (RICCC) has pneumonia and flu vaccine for children and adults as a quality measure and through media campaigns, targets people with chronic disease to obtain flu and pneumonia vaccine.

c. Plan for the Coming Year
The DCFHE will continue to provide all recommended vaccines to providers, free immunizations to uninsured children, and immunization education to providers and to the public. The DCFHE will continue to offer both injectable and intranasal influenza vaccine for children ages six months through 18 years.

The DCFHE continues to provide technical assistance and training for all Vaccine for Children-certified providers. The DCFHE will distribute patient and provider educational and resource materials and host its biannual school nurse teacher conference and its annual immunization event at the Warwick Mall.

The DCFHE plans to visit childcare centers in every community across the state to assess child immunization rates.

In coordination with other DCFHE programs, a revised and updated birthing hospital educational packet will be made available to RI birthing hospitals.

KIDSNET will continue to track the immunization status of all children who receive state supplied vaccine. Messages about the importance of immunizations will be included in KIDSNET-generated cards mailed to families of newborns.

KIDSNET will continue to update the immunization algorithm and data quality reports so that all reports and displayed data reflect current guidelines. Reports regarding invalid doses will be moved to the web for easy accessibility to immunization providers. Ongoing improvements to the reports available for the immunization assessment team are also planned. KIDSNET will continue to expand HL7 interface with electronic medical records and develop web based on-line data entry.

KIDSNET will monitor the use of the immunization report that pediatric providers generate, and will continue to share the use of such reports in a monthly newsletter, at quarterly stakeholder meetings and as a performance measure. KIDSNET will continue to work with managed care

plans to exchange immunization information for health plan performance (HEDIS) reporting and allow health plans direct access to the KIDSNET system.

In coordination with other DCFHE programs, a revised and updated birthing hospital educational packet will be made available to RI birthing hospitals.

The Newborn Developmental Risk Assessment and Screening Program and KIDSNET will continue to capture and store maternal and newborn Hepatitis B information. The Perinatal Hepatitis B Program will continue to provide follow-up and case management for all Hepatitis B positive women and their infants.

The Perinatal Hepatitis B Program will work with Vital Records at the Rhode Island Department of Health to identify home births and assess the HBsAg status of the mother. Hepatitis B positive women who deliver at home will be referred to the Perinatal Hepatitis B Program for case management, to assure completion of the baby's Hepatitis B vaccination series.

The RICCC will continue in over 25 primary care and family practice sites. The flu/pneumonia social marketing campaign will be conducted in FY 2011.

Performance Measure 08: *The rate of birth (per 1,000) for teenagers aged 15 through 17 years.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	20.5	18.3	19.3	18.3	18
Annual Indicator	18.3	18.1	18.0	17.5	17.6
Numerator	361	388	386	364	366
Denominator	19730	21390	21390	20754	20754
Data Source				Vital Records Birth File	Vital Records Birth File
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	17.3	17.3	17.5	17.6	17.6

Notes - 2009
2009: Provisional data indicate that the birth rates for teens aged 15-17 per 1,000 for 2008 - 2009 has remained stable.
Population Estimate for 2008 used for the denominator.

Notes - 2008
Calendar year 2008 data was updated.
Population Estimate for 2008 used for the denominator.

Notes - 2007

2007: Provisional data indicate that the birth rates for teens aged 15-17 per 1,000 for 2004 - 2007 has remained stable.

a. Last Year's Accomplishments

Teen pregnancy is a statewide problem in Rhode Island. Although there is more disparity in the core cities, every community is affected by teen pregnancy. Locally and nationally Hispanic girls have the highest rates of teen pregnancy. Rhode Island has 39 cities and town, of those, 16 cities and towns have birthrates above 20 per 1,000 girls ages 15-19, and 21 cities and towns have birth rates above 15 per 1,000 girls ages 15-19, which is more than half of the cities and towns in the State. Rhode Island teen birth rates are highest in New England and have dropped at the slowest rate in New England.

The DCFHE is committed to reducing teen birth rates and other risk behaviors through a three-pronged approach: 1) access to health care services, within the context of adolescent medical home including family planning, 2) youth development programming that prepares adults and institutions to meet the developmental needs of youth, and engages youth in building skills, attitudes, knowledge and experience that prepare them for the present and future, and 3) coordinated school health programs, including sexuality and family life education within the context of comprehensive health education.

The DCFHE supported Title X family planning clinics to provide reproductive health services to teens. The Women's Health Screening & Referral Program (WHSRP) provided no cost pregnancy testing and comprehensive health risk assessment to teens in Title X clinics; those with a negative pregnancy test were linked to family planning services; those with a positive test were referred to the Adolescent Self-Sufficiency Program. Teens with identified health risks (i.e. smoking, nutrition, mental health services, intimate partner violence, etc.) were referred to appropriate follow-up services.

Youth In Action provided family planning outreach, education, and referral to racially and ethnically diverse young men in Providence to a Title X site.

Participated on an interagency workgroup to use data to better understand teen birth trends. The DCFHE continued to track births to teens and examine trends by demographic factors. The Youth Risk Behavior Survey (YRBS) has been used to look at risk behaviors related to teen risk taking behavior.

Participated, in an advisory capacity, in the newly formed RI Alliance for Teen Pregnancy Prevention that seeks to reduce teen births and repeat births.

The RI Task Force on Premature Births mad recommendations directed at meeting the state's standards to address the need for comprehensive family life and sexuality education in all school districts, expanding and ensuring access to emergency contraception for all women, supporting state policies and programs that ensure access to comprehensive primary and preventive health care services for women (including teens), expanding the range of services in all settings where women (including teenage women) receive health care to include improved identification of health risks, health information, and referrals for health risks associated with preterm birth (including unintended pregnancy), and enhancing comprehensive, relationship family support programs to improve outcomes for women and their children and prevent subsequent teen pregnancy.

DCFHE provided technical assistance to the Northern RI Area Health Education Center ‘s Woonsocket CATCH project to develop a model report on adolescent medical homes, including a common definition and indicators, analysis of a comprehensive community assessment, lessons learned, best practice models, tools for technical assistance and recommendations.

DCFHE's assisted Washington County Coalition for Children's CATCH project to develop a community assessment on teen pregnancy, delayed prenatal care, and food insecurity in

Westerly, RI.

DCFHE worked with the youth action research report designed to determine reasons for high STD and pregnancy among teens, to develop community based approaches to support adolescent

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Provide adolescents with access to confidential family planning services, pregnancy testing, and comprehensive health risk assessment	X			
2. Support the RI Task Force on Premature Birth implementation of recommendations.				X
3. Participate on the statewide RI Alliance for Teen Pregnancy Prevention				X
4. Define and measure medical home models for teens and young adults				X
5. Implement a Youth Consultant Program to strengthen the Division's capacity to involve youth in program development				X
6. Develop a website for parents of 9-17 year olds and professionals				X
7. Continue to track teen pregnancies by demographic and other factors.				X
8. Continue to support community-based AAP/CATCH projects that include a focus on adolescent health.				X
9.				
10.				

b. Current Activities
Family planning services including WHSRP continue to be provided to teens.

The RI Task Force on Premature Birth continued to work on meeting the report recommendations. Among their numerous efforts described here in, their work resulted in the formation of the Nurse Family Partnership in RI.

DCFHE engaged minority youth in Photovoice ethnographic research and recommendation setting around community health issues in their communities and shared results within HEALTH and at the New England Regional Minority Health Promotion Conference held in Providence, RI.

Data from the YRBS was also analyzed by differences among individuals with respect to disability status, sexual orientation and academic performance. Youth who reported having a disability, being gay lesbian bisexual or unsure , or poor academic performance were all at higher risk for many of the health risk behaviors on the YRBS including those that are risk factors for teen pregnancy.

DCFHE supports efforts of the RI Alliance for Teen Pregnancy Prevention. DCFHE applied for Teen Pregnancy Prevention Replication of Evidence Based Program funding and other opportunities through HRSA.

DCFHE's supported Woonsocket CATCH grant partners and Washington County CATCH on efforts to reduce teen pregnancy. .

DFCHE and CHDA participate with RIDE on the development of a new school based survey for

students, teachers and parents, to measure teaching and learning in RI schools including health concerns that influence learning.

c. Plan for the Coming Year

The DCFHE will continue to provide teens with access to family planning services, pregnancy testing, and comprehensive health risk assessment. DCFHE will continue to implement and work to expand the WHSRP to assure that youth and young adults seeking pregnancy tests receive referrals to risk prevention services and family planning as appropriate. Youth in Action will continue to provide family planning outreach, education, and referral to young men in Providence.

The RI Task Force on Premature Birth will continue to work on implementing its recommendations. Specifically, the Comprehensive Family Life and Sexuality Education work group will distribute and evaluate the health curriculum needs assessment survey among Rhode Island health educators and school nurses. The Emergency Contraception work group will evaluate the project by asking providers and pharmacists if they received the materials and ask them a few basic questions on how they are using them. The workgroup monitoring maternal and child health legislation will continue to monitor legislation dealing with access to health care for women of childbearing age and their children. The Task Force will continue to support policy and legislation. The work group focused on expanding the range of services in all settings where women receive health care to include improved identification of health risks, health information, and referrals for health risks associated with preterm birth (including unintended pregnancy) will determine how it can build upon recommendations made and develop priority areas for action steps. Family Nurse Partnership services will be provided to multiple-risk, first time families in several communities.

The DCFHE will continue to work on adolescent medical homes with the Woonsocket CATCH grant project and the Washington County Coalition for Children's CATCH project in Westerly that focuses on teen pregnancy, delayed prenatal care and food insecurity. .

The DFCHE will develop opportunities to work with communities on adolescent health issues, developing assets and reducing health risks. The DFCHE will seek new opportunities to engage youth in action research in a variety of health risk areas.

DFCHE will develop a web resource for teens and parents of teens to provide parents and providers with connection to programs and resources and will continue to be promoted as part of a coordinated communications strategy.

The DCFHE will continue to track births to teens and examine trends by demographic factors.

Performance Measure 09: *Percent of third grade children who have received protective sealants on at least one permanent molar tooth.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	51.9	54	34.3	36.3	36.9
Annual Indicator	32.7	33.2	36.3	38.6	38.6
Numerator	4780	4230	4625	4625	4625

Denominator	14628	12740	12740	11987	11987
Data Source				Oral Health Program	Oral Health Program
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	39.5	39.9	39.2	39.2	39.5

Notes - 2009
2009 data are estimated. Denominator from 2008 Population Estimate.
The Basic Screening Survey (BSS) was conducted in the fall of 2007. The BSS was funded by the CDC and conducted in 35 States.
In Rhode Island, 31 public elementary schools were randomly selected
and 66 percent of the enrolled 3rd grade students were screened.
The actual number of 3rd graders screened was 1303.

The Oral Health Program is working with the RI Department of Education (RIDE) and the RI Oral Health Commission to standardize screening forms utilized by school dentists. RIDE will be revising their Rules & Regulations Pertaining to School Health Programs, and the Oral Health Program is working with school dentists to include presence of sealants in the Rules & Regulations. Once included, we will be developing a standardized form based on the required screening conditions, as outlined in the Rules & Regulation, and will recommend that all school dentists utilize the form and return it to the Oral Health Program for input and analysis. It is anticipated that, once established, this procedure will provide the Oral Health Program with data to support more accurate tracking of the Title V National Performance Measure related to placement of dental sealants in RI children.

Additionally, to support RI's ability to increase the number of children receiving dental sealants, the 2010 Title V budget application will include funding for school-based dental programs to increase the number of children receiving services, including dental sealants.

Notes - 2008
2008 data are estimated.
The Basic Screening Survey (BSS) was conducted in the fall of 2007. The BSS was funded by the CDC and conducted in 35 States.
In Rhode Island, 31 public elementary schools were randomly selected
and 66 percent of the enrolled 3rd grade students were screened.
The actual number of 3rd graders screened was 1303.

Denominator from 2008 Population Estimates.

Notes - 2007
The Basic Screening Survey (BSS) was conducted in the fall of 2007. The BSS was funded by the CDC and conducted in 35 States.
In Rhode Island, 31 public elementary schools were randomly selected
and 66 percent of the enrolled 3rd grade students were screened.
The actual number of 3rd graders screened was 1303.

Denominator from US Census estimate.

a. Last Year's Accomplishments

The 2007-08 RI third grade oral health basic screening survey revealed that 31% of third graders living in Rhode Island's core cities had dental sealants on at least one molar tooth. These results indicate that RI falls far short of national standards and needs to promote delivery systems and use of dental sealants as an important preventive measure among medical and dental practitioners. Annual MCH Title V reports require annual data collection to measure RI's performance. Institution of the proposed project to expand the dental sealant program will assure collection of this data on schedule.

In FY2009, the DCFHE continued to work with numerous state agency and community partners to improve children's access to oral health services and prevent dental caries in children.

Parents of young children receiving home visiting services through the First Connections Home Visiting Program continued to receive culturally and linguistically appropriate information and education about early childhood caries and the importance of preventive dental care.

Families receiving WIC services were provided with information about early childhood caries.. All local WIC staff were offered technical training on oral health topics. Education materials addressing oral health issues were developed by the WIC Program in conjunction with HEALTH's Oral Health Program and are currently used during counseling during WIC certification appointments. Through this grant, HEALTH promotes "common sense" oral health practices for young children by teaching parents and Head Start providers about early childhood tooth decay prevention. The "common sense" practices include drinking fluoridated water, daily brushing with fluoridated toothpaste, and annual visits to a dentist.

The DCFHE continued to participate on the Rhode Island Oral Health Commission, a statewide coalition of public, private, and not-for-profit stakeholders working to improve the oral health of all Rhode Island residents, including school-age children, and CSHCN. Additionally HEALTH and the Commission are working to increase access to primary and preventive dental services for children and families covered by Medicaid and for Rhode Islanders underserved for dental care.

The Center for Health Data and Analysis continued to survey mothers of two year-olds via the Toddler Wellness Overview Survey (TWOS), which includes questions related to oral health.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Administer the First Connections Program, which provides culturally and linguistically appropriate information and education about early childhood caries and the importance of preventive dental care		X		
2. Continue to provide families receiving WIC services with culturally and linguistically appropriate information and education about early childhood caries and the importance of preventive dental care		X		
3. Support school-based health centers in providing children and youth with direct access to and/or referrals to oral health services	X			
4. Provide technical assistance, consultation, and materials on children’s oral health issues to child care providers and parents through the Child Care Support Network			X	
5. Support the activities of the Oral Health Program, including participation on the program’s Early Childhood Oral Health Coalition				X

6. Continue to collect and analyze oral health data from the Toddler Wellness Overview Survey				X
7.				
8.				
9.				
10.				

b. Current Activities

The First Connections Home Visiting/ WIC programs provide culturally appropriate information about early childhood caries/prevention. The Child Care Support Network, Child Care Health Consultants offers health consultation to child care centers conducting child health record reviews, providing staff training and technical assistance, distributing educational materials, and working directly with families to provide referrals to community services and resources..

School-based dental/sealant programs are located in several Rhode Island communities. The Association of State and Territorial Dental Directors (ASTDD), recommends that schools with 50% or more students eligible for free or reduced school meals (FRL) programs are targeted for school-based services. Currently, 34% (n=67) of RI elementary schools meet eligibility criteria but are not associated with a school-based dental/sealant program. Two school based health centers refer adolescents to oral health services as necessary.

The DCFHE hosted the 2010 State Oral Health Summit to solicit feedback on the draft 2010 RI Oral Health Plan. Once finalized, the RI Oral Health Plan will be widely disseminated to policymakers and oral health stakeholders statewide.

TWOS data continue to be collected and analyzed.

c. Plan for the Coming Year

The DCFHE will continue to work to prevent dental caries and increase children's access to oral health services by integrating education into DCFHE programs and by working with other key partners to strengthen the state's dental services infrastructure.

Parents of young children who receive home visiting services through the First Connections Home Visiting Program will continue to receive culturally and linguistically appropriate information and education about early childhood caries and the importance of preventive dental care.

Families receiving WIC services will continue to be provided with culturally and linguistically appropriate information about early childhood caries and the importance of preventive dental care.

DFCHE supported SBHCs provide dental services to children and youth at their main health enter sites.

The Child Care Support Network continues to offer health consultation to child care centers and family child care homes throughout the state. Trained consultants (nurses) will conduct child health records review, provide staff training and technical assistance on issues related to preventative health and safety, distribute educational materials, and will work directly with families to provide referrals to community services and resources. Oral/dental health will be included in the range of physical and developmental health issues that the health consultants will address.

The DCFHE will continue to support the work of HEALTH's Oral Health Program. In FY2010, the Oral Health Program will finalize and disseminate the RI Oral Health Plan. The Oral Health Program has submitted an application to HRSA to integrate oral health into all general health materials (intake forms, questionnaires, educational materials, etc.) utilized by CSHCN

counselors through the Support to States for Oral Health Workforce Activities. Additionally, the Oral Health Program and RI communities support the inclusion of funding for school-based dental/sealant programs in the Title V application to continue this important service for high-risk children. As noted above, 34% (n=67) of RI elementary schools meet the eligibility criteria for high risk for oral disease, but are not associated with a school-based dental/sealant program. Title V funding for school-based dental/sealant programs would assist in expansion of these programs to high-risk schools and potentially decrease the oral disease in this population.

The CHDA will continue to conduct the TWOS survey and analyze responses to the oral health questions.

Performance Measure 10: *The rate of deaths to children aged 14 years and younger caused by motor vehicle crashes per 100,000 children.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	1.5	1.5	1.5	1.5	1.5
Annual Indicator					
Numerator					
Denominator	186874	181152	181152	173303	17303
Data Source				Vital Records Death File	Vital Records Death File
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.			Yes	Yes	Yes
Is the Data Provisional or Final?				Provisional	Provisional
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	1	1	1.5	1.5	1.5

Notes - 2009
Data for 2008 reflect children aged 1 -14.
Denominator is from the 2008 Population Estimates.

Issue: Rhode Island has not been able to report on PM 10 due to the number of events. There are fewer than 5 events over the last year and the average of the last 3 years is also fewer than 5.

Notes - 2008
Data for 2008 reflect children aged 1 -14.
Denominator is from the 2008 Population Estimates.

Issue: Rhode Island has not been able to report on PM 10 due to the number of events. There are fewer than 5 events over the last year and the average of the last 3 years is also fewer than 5.

Notes - 2007

Data are for children aged 1 -14.
Denominator is from the US Census Estimates.

a. Last Year's Accomplishments
According to data from the Centers for Disease Control and Prevention, National Centers for Injury Prevention and Control. Web-based Injury Statistics Query and Reporting System (WISQARS™), there were three deaths of children ages 14 and younger from motor vehicle accidents in Rhode Island in 2007. This figure represents a decline from the 2001 figure of 4 deaths among this age group from motor vehicle accidents and continues to be lower than the national death rate. According to WISQARS™, nationally the death rate for children ages 14 and younger from motor vehicle accidents decreased from 3.71 per 100,000 in 2001 to 2.80 per 100,000 in 2007; while the Rhode Island death rate has decreased during this time period from 1.93 to 1.59.

The number of deaths to children ages 14 years and younger caused by motor vehicle crashes in Rhode Island is very small. In 2007, motor vehicle accidents resulted in three child deaths.

In FY2009, First Connections continued to provide families with young children culturally and linguistically appropriate information regarding the proper use of car seats, air bag safety, and the safest location in the car for children (i.e. the back seat). Low-income families receiving homes visits were referred to the RI Safe Kids Coalition, which provides free care seats to low-income families.

Healthy Child Care Rhode Island, through the Child Care Support Network, continued to provide informational materials to families with children in child care and child care providers on the proper use of car seats, air bag safety, and the safest location in the car for children.

Deaths to children caused by motor vehicle crashes where the driver was impaired due to alcohol and/or drug intoxication is a public health concern in Rhode Island as well as the rest of the country. The Women's Health Screening & Referral Program (WHSRP) provides free pregnancy testing and comprehensive health risk assessment to women receiving pregnancy testing services in eight Title X family planning sites. As a part of the WHSRP, women are assessed for risks related to substance abuse and referred for appropriate substance abuse evaluation and/or treatment services. In 2006, 21% of the women who participated in the WHSRP reported they used alcohol and/or drugs.

Recommendations made by the RI Task Force on Premature Births included encouraging development of additional substance abuse treatment programs where women are not separated from their children and where parental relationships for women in treatment are preserved.

DCFHE staff continued to participate on the Child Death Review Team, a multidisciplinary team led by the State Medical Examiner's Office that reviews childhood deaths to identify risk factors and trends, and to inform prevention efforts. In Rhode Island, all deaths under 18 years of age regardless of cause must be reported to the Medical Examiner's Office. The team is committed to the systematic, multidisciplinary review of these deaths. Encourage community-based partners, legislators, and public policymakers to take action to prevent other deaths and improve the safety and wellbeing of all children. The ultimate goal of the team is to reduce the number of child deaths in the state.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Continue to support the First Connections Program to provide families with young children with culturally and linguistically	X			

appropriate information and education about automobile safety				
2. Refer families to the RI Safe Kids Coalition, which provides free car seats to low-income families		X		
3. Provide culturally and linguistically appropriate information and technical assistance to families with children in child care settings and child care providers about automobile safety through the Child Care Support Network			X	
4. Refers risk positive women who receive pregnancy tests to substance abuse assessment and/or treatment services through the Women's Health Screening & Referral Program	X			
5. Continue to participate on the Child Death Review Team led by the State Medical Examiner, which reviews child deaths to determine whether they were preventable			X	
6. Support the Task Force on Premature Births to implement recommendations to reduce the rate of prematurity in Rhode Island.			X	
7. Include mental health screening tools in school and community settings.			X	
8.				
9.				
10.				

b. Current Activities
First Connections continues to provide families with young children information regarding the proper use of car seats, air bag safety, and the safest location in the car for children. Low-income families receiving home visits continue to be referred to the RI Safe Kids Coalition.

The Child Care Support Network, Child Care Health Consultants provides informational materials regarding overall injury prevention, including proper use of car seats, air bag safety, and the safest location in the car for children to families with children in child care and to child care providers. Health consultants in child care centers provide information and technical assistance on a variety of child health and safety topics, including automobile safety.

The Women's Health Screening & Referral Program (WHSRP) continues refer women with risks related to substance abuse are referred for appropriate substance abuse evaluation and/or treatment services.

The Task Force on Premature Births work group aligning its efforts with the Women and Addiction Recovery Task Force of the Institute for Addiction Recovery at Rhode Island College.

The DFCHE will continue to track children's death caused by motor vehicles and examine trends by demographic factors and to participate on the Child Death Review Team led by the State Medical Examiner.

DFCHE and CHDA participate with RIDE on the development of a new school based survey for students, teachers and parents.

c. Plan for the Coming Year
The DCFHE will continue to work to reduce the number of deaths to children caused by motor vehicle crashes.

First Connections will continue to provide families with young children culturally and linguistically

appropriate information regarding the proper use of car seats, air bag safety, and the safest location in the car for children (i.e. the back seat).

The Child Care Support Network will continue to provide informational materials regarding the proper use of car seats, air bag safety, and the safest location in the car for children to families with children in child care and to child care providers. The Child Care Support Network will begin offering health consultation to child care centers and family child care homes throughout the state. Health consultants will provide information and technical assistance on a variety of child health and safety topics, including automobile safety.

The Women's Health Screening & Referral Program (WHSRP) will continue to provide free pregnancy testing and comprehensive health risk assessment to women receiving pregnancy testing services in Title X family planning sites. As a part of WHSRP, women are assessed for risks related to substance abuse and referred for appropriate substance abuse evaluation and/or treatment services.

A Task Force on Premature Births work group will continue to work to align its efforts with the work being done through the Women and Addiction Recovery Task force of the Institute for Addiction Recovery at Rhode Island College.

DCFHE personnel will continue to participate on the Child Death Review Team led by the State Medical Examiner, which reviews child deaths to determine whether they were preventable.

DCFHE's SafeRI _ Violence and Injury Prevention Program plans to apply for CDC core injury prevention funds for childhood injury policy development.

DCFHE will continue to use YRBS data to measure the impact of alcohol and substance abuse as it relates to motor vehicle crashes.

DCFHE will work with pediatricians, school leaders and other stakeholders to include mental health screening tools in school and community settings.

DCFHE will continue to work with the Woonsocket CATCH grant coalition, to provide technical assistance and tools to support the development of adolescent medical homes in Woonsocket. DCFHE will identify two more communities to pilot the adolescent home model.

Performance Measure 11: *The percent of mothers who breastfeed their infants at 6 months of age.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective		28.5	31.5	32.5	42.5
Annual Indicator	32.9	35.4	43.4	40.4	40.4
Numerator	4175	4523	5507	4997	4998
Denominator	12690	12778	12690	12370	12371
Data Source				National Immunization Survey	National Immunization Survey
Check this box if you cannot report the numerator because 1.There are fewer than 5 events					

over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	42.5	43.2	43.5	44.5	44.8

Notes - 2009
Data Source: National Immunization Survey [NIS] Breastfeeding Report Card - United States 2009. Children surveyed each year were born about 2 years prior to survey. Therefore, denominator reflects Rhode Island resident births for 2007.
Although the rate remained the same for 2008 & 2009, there was a slight decline from 2007. However, the decline is not considered statistically significant.

Notes - 2008
Data Source: National Immunization Survey [NIS]. The years presented in the above table reflect the survey year. Children surveyed each year were born about 2 years prior to survey. Therefore, denominator reflects Rhode Island resident births for 2006.

Data for 2008 are provisional and an estimate from the 2008 NIS. Based on the 95% CI, the rate declined from 2007 to 2008 but is not considered statistically significant. According to the 2008 NIS survey, 40.4% of Rhode Island women breastfed their infants at 6 months of age compared to 43.4% in 2007.

Notes - 2007
Data Source: National Immunization Survey [NIS]. The years presented in the above table reflect the survey year. Children surveyed each year were born about 2 years prior to survey. Therefore, denominator reflects Rhode Island resident births for 2005

Data for 2007 are final and based on the 95% CI, the rate increased from 2006 to 2007, however it was not statistically significant. According to the 2007 NIS survey, 43.4% of Rhode Island women breastfed their infants at 6 months of age compared to 35.4% in 2006.

The 35.4% reflects the updates rate from NIS for 2006, which I was unable to enter.

a. Last Year's Accomplishments
Rhode Island continues to prioritize supporting breastfeeding. Rhode Island is working with birthing hospitals to increase the number that are baby friendly since research shows that increasing the number of women who initiate breastfeeding will impact the number of those continuing to breastfeed at 6 months of age. RI has made working with employers to support breastfeeding a priority, recognizing employers who provide a place for women to breastfeed as well as distributing hospital grade electric breast pumps to WIC clients who are fully breastfeeding and are returning to work.

The DCFHE continued to work to increase the percentage of mothers who breastfeed their infants at birth and at six months of age.

The WIC Program continued to support a lactation support program for WIC participants six days a week in a birthing hospital. Mothers who receive adequate lactation support after giving birth are more likely to continue breastfeeding after they leave the hospital. WIC also continued to support a "mother-to-mother" peer counselor program to provide culturally competent breastfeeding support to WIC participants at 10 of the 11 WIC sites and at the state's largest birthing hospital. Peer counselor trainings were held every six months to minimize service interruptions. WIC also sponsored WIC staff to attend a Certified Lactation Counselor training to

ensure skilled and consistent breastfeeding services.

The DCFHE maintained partnerships with the RI Breastfeeding Coalition (RIBC) and the Physicians' Committee for Breastfeeding in RI (PCBRI) and collaborated with these groups to update and carry out the initiatives of the statewide breastfeeding promotion plan. The DCFHE actively promoted adoption of the Baby-Friendly Hospital Initiative, a global program developed to encourage and recognize hospitals that offer an optimal level of care for lactation. The WIC program instituted an electronic breast pump program to provide pumps to fully breastfeeding women who are returning to work or school. DCFHE collaborated with RIBC, PCBRI, and health insurers to ensure the availability of electric breast pumps for low-income families. The DCFHE Initiative for a Healthy Weight (IHW) direction is outlined in its Eat Smart Move More Plan for Action 2010-2015, which includes objectives to promote DHHS's Business Case for Breastfeeding and recognizes worksites that effectively accommodate breastfeeding mothers. IHW provided funds to the RI Breastfeeding Coalition to increase worksites that support breastfeeding mothers.

During World Breastfeeding Week the DCFHE engaged state officials and the local media to recognize employers as Breastfeeding-Friendly Workplace Award in partnership with PCBRI. The WIC Program provided local WIC agencies with special funds to purchase sustainable breastfeeding promotion materials and to sponsor breastfeeding promotion events at their clinics.

The DCFHE continued to support the toll-free Family Health Information Line. Bilingual staff took calls from breastfeeding women and referred them to appropriate community resources. The DCFHE continued to distribute culturally and linguistically appropriate materials to health care providers and low-income families through hospitals, agencies, and private practices to facilitate the provision of accurate and consistent breastfeeding messages. WIC breastfeeding brochures were distributed within and beyond WIC sites. The DCFHE continues to update the breastfeeding resource website for parents, employers and health care providers.

KIDSNET continued to track the percent of mothers that breastfeed through First Connections Program and newborn developmental screening data. The DCFHE conducted both RI PRAMS and TWOS surveys which asks respondents about breastfeeding practices. PRAMS asks the mother whether she ever breastfed, whether she is still breastfeeding, and about barriers to breastfeeding. TWOS asks if the respondent ever breastfed and the duration she breastfed.

PRAMS survey data was collected and analyzed.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Support a lactation support program for WIC participants in birthing hospitals	X			
2. Continue to support a "mother-to-mother" peer counselor program to provide culturally competent breastfeeding support to WIC participants in WIC sites and the state's largest birthing hospitals		X		
3. Sponsor WIC peer counselors and nutritionists to attend a Certified Lactation Counselor training.				X
4. Collaborate with key partners to update and implement the statewide breastfeeding promotion plan				X
5. Continue to enhance the statewide breastfeeding support infrastructure through partnerships with health insurers, visiting nurse agencies, birthing hospitals, and other community groups and agencies				X

6. Continue to disseminate culturally and linguistically appropriate breastfeeding informational materials targeting low-income families through WIC agencies and health care provider offices		X		
7. Update and distribute breastfeeding resources, including the breastfeeding website, Breastfeeding Resource Directory, and Breastfeeding Pocket Guide			X	
8. Continue to support the toll-free Family Health Information Line to refer breastfeeding callers to appropriate community resources			X	
9. Collect and track breastfeeding information through KIDSNET, the First Connections Program, PRAMS, and TWOS				X
10. Continue to promote the Business Case for Breastfeeding workplace award.				X

b. Current Activities

WIC lactation support services are available 6 days a week in the state's largest birthing hospital. All WIC clients as well as those who are eligible for the program who are breastfeeding are visited by lactation consultant and a report is sent to the local WIC site so consistent follow-up is provided. WIC supports a "mother-to-mother" peer counselor program, Certified Lactation Counselor training for WIC peer counselors and nutritionists, a peer counselor program, and a statewide breast pump loan program. WIC collaborates with Parent Consultants to share resources across programs.

IHW continues to support the RIBC to implement a Breastfeeding Friendly Workplace Award and to promote the Business Case for Breastfeeding. The DCFHE is promoting the Baby-Friendly Hospital Initiative, and collaborating with health insurers to define/deliver contractual breastfeeding benefits. The DCFHE partners with the PCBRI on Breastfeeding Friendly Workplaces and the RIBC on World Breastfeeding Week.

The Family Health Information Line refers breastfeeding women/health care providers to resources. Consumer breastfeeding info is distributed to health care providers/families through hospitals, agencies, and private practices. The RI Breastfeeding Resource Directory and Breastfeeding Pocket Guide for Providers are made available to providers. A breastfeeding website is updated and maintained.

c. Plan for the Coming Year

DCFHE will continue to work to increase the percentage of mothers who breastfeed their infants at birth and at six months of age. The First Connections MCH home visiting team will continue to consist of staff that is Certified Lactation Counselors who support mothers who want to breastfeed their child.

The WIC Program will continue to support visits by lactation consultants to WIC participants in the state's largest birthing hospital. WIC will also continue to support a "mother-to-mother" peer counselor program to provide culturally competent breastfeeding support at WIC sites and in the state's largest birthing hospital. Peer counselor trainings and Certified Lactation Counselor Certificate training will continue to ensure skilled and consistent breastfeeding services. WIC will be providing a 3 day training to all staff to support key breastfeeding messages throughout a WIC appointment.

WIC will continue to co-sponsor educational talks and events for health care providers and will continue to work on instituting and sustaining a statewide electric breast pump loan program.

The Child Care Support Network health consultants will provide child care providers with information about promoting breastfeeding for families and also assistance in how to help support mothers who want to breastfeed their child while he/she is in out of home child care.

IHW will continue its funding of the RIBC to implement the Breastfeeding Friendly Workplace Award and to promote the Business Case for Breastfeeding. The DCFHE will continue to collaborate with health insurers to enhance and deliver breastfeeding insurance benefits, to partner with PCBRI each year to recognize Breastfeeding-Friendly Workplaces, and to sponsor birthing hospitals to adopt the Baby-Friendly Hospital Initiative. The new public breastfeeding law will be actively promoted to employers.

DCFHE will continue to support World Breastfeeding Month activities and media promotion to encourage women to breastfeed their infants. The WIC Program will also continue to provide WIC agencies with special funds to purchase breastfeeding promotion materials and to sponsor World Breastfeeding Month events.

DCFHE will continue to support the toll-free Family Health Information Line to refer breastfeeding women and providers to appropriate community resources, and to distribute culturally and linguistically appropriate breastfeeding materials to health care providers and low-income families through hospitals, agencies, and private practices and will continue to update the breastfeeding website.

KIDSNET continued to track the percent of mothers that breastfeed through First Connections and newborn developmental screening data.

The Child Care Support Network health consultants will provide child care providers with information about promoting breastfeeding for families and also assistance in how to help support mothers who want to breastfeed their child while he/she is in out of home childcare.

Performance Measure 12: *Percentage of newborns who have been screened for hearing before hospital discharge.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	99.5	99.5	96.5	97.3	98.9
Annual Indicator	99.4	98.7	98.8	99.4	99.2
Numerator	13336	12960	12971	12683	12082
Denominator	13416	13127	13133	12758	12179
Data Source				Universal NewBorn Screening	Universal NewBorn Screening
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2010	**2011**	**2012**	**2013**	**2014**

Annual Performance Objective	99.4	99.4	99.6	99.6	99.6

Notes - 2009
2009 : Data was provided by the Kidsnet Database [Universal NewBorn Screening] and reflects total screened before DISCHARGE.
Denominator reflects births occurring in Rhode Island minus 51infants deaths.

Notes - 2008
2008: Data was provided by the Kidsnet Database [Universal NewBorn Screening] and reflects total screened before DISCHARGE.
Denominator reflects births occurring in Rhode Island minus 45 infants deaths.

Notes - 2007
Data for 2007 was provided by the Kidsnet Database and reflects total screened before DISCHARGE.

Denominator reflects births occurring in Rhode Island minus 58 infants deaths.

a. Last Year's Accomplishments
Data Discussion:
Annual data shows that Rhode Island continues to maintain high rates of newborn hearing screening. Over 99% of all babies born in Rhode Island receive a hearing screen (99.7%). Babies with positive or inconclusive results are referred for a re-screen. The state has put quality assurance systems in place to ensure that these high rates of screening are maintained.
Data is not available related to hospital discharge. It is tabulated for the national performance measure "screened by one month of age". In 2008, there were 12,812 occurrent births. 12,668 (99%) were screened, 112 died or refused screening, and 32 were not screened for other reasons. Of the 12,668 screened, 12,408 (97% of all occurent births) were screened by one month of age. An additional 240 were screened prior to 3 months of age and 20 after 3 months. There are good systems in place to track and assure that every baby is screened and the screening rates are very high. Very few infants are ever discharged without a screen and there is even a system in place to identify home births in need of screening. The newborn hearing screening program is more focused on assuring that the infants who are referred for diagnostic audiology receive that service as those families are more likely to be lost to follow-up.

a. Last Year's Accomplishments
The RI Hearing Assessment Program (RIHAP) ensures that all newborns receive hearing screening prior to hospital discharge. The DCFHE utilizes KIDSNET to track RIHAP screening information, which originates through the newborn screening process. Infants with confirmed hearing impairment are referred to the RI School for the Deaf Family Guidance Program and Early Intervention. First Connecitons Program home visitors also continue to track infants who are lost to follow-up by RIHAP. The newborn hearing screening database is pre-populated with birth information collected on an integrated newborn developmental risk assessment and birth certificate system then sent to KIDSNET. Two way data exchange between KIDSNET and RITrack allows RIHAP to match birth data to assure that all infants have a hearing screen with a result in KIDSNET. RIHAP and KIDSNET follows up when a child was missed or if the data was never entered into KIDSNET. Rhode Island-specific Newborn Hearing Screening process algorithms adopted from the American Academy of Pediatrics Early Hearing Detection and Intervention (EHDI) guidelines were mailed to primary care providers caring for infants. A system was put into place to mail the algorithm to providers when a newborn in their practice requires follow-up related to the newborn hearing screen.

Informing brochures continued to be distributed in English and Spanish at three time points (prenatal, perinatal, postnatal). The brochures include information on several programs including bloodspot, hearing, developmental risk, home visiting, birth defects surveillance, and KIDSNET. RI PRAMS continues to collect data on parental awareness that babies are tested in the hospital

for hearing loss.

The Birth Defects Program and KIDSNET continues to work with the Newborn Screening Program to ensure that a final diagnosis of hearing loss in an infant is recorded and reported to the Birth Defects Program.

The newborn hearing screening quality assurance committee continued to meet. Representatives from the Newborn Screening Program, the Family Guidance Program at the RI School for the Deaf, and Early Intervention meet quarterly to assure that every baby referred has had audiological evaluation and that every baby diagnosed with a hearing loss is enrolled in Family Guidance and Early Intervention (or the parents have chosen not to participate). In FY2008 a PPEP parent consultant was added to the RIHAP follow up team. The parent consultant answers parents' questions about the screening process and assists the family in compliance with follow-up appointments.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Ensure universal newborn hearing screening prior to hospital discharge			X	
2. Ensure that infants identified with hearing impairment are referred to the RI School for the Deaf and Early Intervention		X		
3. Continue to support the First Connections Program to track infants lost to follow-up by the RI Hearing Assessment Program		X		
4. Utilize KIDSNET to track hearing screening information and refer newborns who do not have a hearing screening to the RI Hearing Assessment Program for follow-up				X
5. Continue efforts to connect all pediatric audiologists in the state to KIDSNET				X
6. Continue to work to ensure that a final diagnosis of hearing impairment is recorded and reported to the Birth Defects Program				X
7. Collect and analyze information on family awareness about newborn hearing screening through PRAMS				X
8. Distribute integrated culturally and linguistically appropriate brochures that include hearing screening			X	
9.				
10.				

b. Current Activities

All newborns receive hearing screening prior to hospital discharge with results tracked in KIDSNET. Infants identified with hearing loss are referred for the appropriate services. The First Connections Program home visitors track infants lost to follow-up by RIHAP. The Birth Defects Program, Newborn Screening Program and KIDSNET ensure that a final diagnosis of hearing loss in an infant is recorded and reported.

KIDSNET continues to send RIHAP electronic birth records to assure all newborns were screened and a hearing screening result in KIDSNET. The RIHAP program is now providing the hearing results to the parents prior to discharge along with the newborn screening brochure. If follow up is necessary an appointment is scheduled prior to discharge. Audiologists are connected to KIDSNET, making newborn hearing screening results available to these professionals. Programming to allow for reporting of diagnostic audiology tests into KIDSNET near completion

The DCFHE continues to distribute integrated newborn screening brochures to families when the hearing screening is completed in the hospital along with a system for distribution of similar brochures at the prenatal and postnatal time points. The postnatal brochure discusses the importance of following up on recommendations received following newborn hearing screening All brochures including the Resource Guide for Families of Children who are Deaf or Hard of Hearing is available in English and Spanish.

c. Plan for the Coming Year

RIHAP will continue to assure that all newborns receive hearing screening prior to hospital discharge. The DCFHE will utilize KIDSNET to track RIHAP screening information, which originates through the newborn screening process. Infants who are identified with hearing loss will continue to be referred to the RI School for the Deaf Family Guidance Program and to Early Intervention where they will have access to a PPEP parent consultant. First Connections Program home visitors will also continue to track infants who are lost to follow-up by RIHAP.

A new protocol to address infants lost to follow up will be developed by RIHAP, PPEP parent consultant, and First Connections. KIDSNET will continue to send RIHAP a report that indicates which children do not have a hearing screening result in KIDSNET. RIHAP will follow-up to identify whether the child was missed or if the data was never entered into KIDSNET. KIDSNET will continue efforts to train all pediatric audiologists to access newborn hearing screening results and Early Intervention information and to use on-line diagnostic reporting into KIDSNET once that feature is available.

The DCFHE will continue to distribute integrated newborn screening brochures to families at the prenatal, hospital, and postnatal time periods. This brochure discusses the importance of following up on recommendations received following newborn hearing screening and is available in English and Spanish.

A family version of the newborn hearing-screening algorithm will be distributed in English and Spanish to families of infants requiring follow-up after the newborn hearing screen. Upgrades to the HEALTH and RIHAP websites will be completed. The DCFHE will continue to distribute the Resource Guide for Families of Children who are Deaf or Hard of Hearing to assist families in navigating and accessing services.

The Birth Defects Program will continue to work with the Newborn Screening Program and KIDSNET to ensure that a final diagnosis of hearing loss in an infant is recorded and reported. In addition, RI PRAMS will continue to survey recent mothers regarding parental knowledge that babies are tested in the hospital for hearing loss. PRAMS will provide data to evaluate if introduction of the brochures or family algorithm is related to an increase in awareness, particularly among subpopulations such as Spanish-speakers.

Performance Measure 13: *Percent of children without health insurance.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	5.4	7.2	7.5	5.7	8.8
Annual Indicator	7.6	4.1	8.8	7.9	7.5
Numerator	19114	9735	20944	18644	17587
Denominator	251500	237451	238000	236000	234500

Data Source				CPS - Table HIA-5	CPS - Table HIA-5
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	7.3	7.6	7.6	7.2	7.2

Notes - 2009
2009 Data is from US Census Bureau March Current Population Survey [CPS]:
Table HIA-5: Health Insurance Coverage Status and Type of Coverage by State - Children under 18. Data are updated to reflect the most recent tables provided. Both numerator and denominator are from Table HIA-5.

Notes - 2008
2008 Data is from US Census Bureau March Current Population Survey [CPS]:
Table HIA-5: Health Insurance Coverage Status and Type of Coverage by State - Children under 18. Data are updated to reflect the most recent tables provided.

Notes - 2007
2007 Data are from US Census Bureau March Current Population Survey [CPS]:
Table HIA-5: Health Insurance Coverage Status and Type of Coverage by State - Children under 18. Data are updated to reflect the most recent tables provided.

a. Last Year's Accomplishments
Following a steady decline in uninsured children in RI from 10.9% in 1994 to 4.3% in 2001, the rate of uninsurance in children has slowly crept upward to 8.7% in 2007-2008. The increase is partly due to the decrease in employer-sponsored health insurance in RI; in 2007-2008 only 59.1% of children 0-18 were covered by employer-offered insurance, compared to 73.3% in 1999-2001. The sharp rise in health insurance premiums (up 122% from 1999 to 2009) made employee co-shares unaffordable for many workers, as well making employer costs prohibitive. Over the past two years unemployment in RI has been near the highest in the nation, forcing more families out of employer-sponsored health insurance. The rate of uninsurance for poor RI children (under 100% FPL) was 18.5% in 2007-2008, more than twice the rate for all children. It is estimated that between 2006 and 2008, 72% of uninsured RI children in were eligible for RIte Care but not enrolled.

Rhode Island is committed to ensuring that all children have access to insurance and quality health care. Family Health Information Line Information Specialists and parent consultants working in the DCFHE continued to receive training about RIte Care and assisted with outreach activities. Information Specialists continued to refer callers without health insurance to RIte Care. DCFHE and PPEP parent consultants partner with Neighborhood Health Plan of RI for targeted outreach to families whose RIteCare is due to expire.

Numerous DCFHE programs refer families who are uninsured or underinsured to FRCs in the community and directly to Medicaid. In 2007, RIte Care enrollment among WIC participants rose to 85% (up from 75.1% in 2000). The PPEP assisted over 2200 families with CYSHCN in 2007 on issues concerning insurance, education, and access to mental health services; nearly 25% of these families required direct assistance in accessing health insurance. School-Based Health

Center in two schools refer uninsured students to RIte Care. The First Connections Program and the Child Care Support Network also referred uninsured or underinsured families with young children to RIte Care

Child care health consultants work with licensed child care providers to ensure that all of the children in their care have access to health insurance and facilitate the enrollment of those who are eligible but not enrolled.

First Connections Program workers will provide information to all families receiving a home visit about new Medicaid recertification requirements. First Connections workers will continue to worked with the Department of Human Services to streamline the recertification process.

The DCFHE also provided technical assistance to several local CATCH projects and community coalitions, including projects in Providence, Woonsocket, and Westerly, RI. to build the capacity of medical homes and link children and families to needed health and human services. The DCFHE was also a key partner in Covering Kids Rhode Island, a coalition of partners working statewide and in local project communities to ensure that all children and adults eligible for RIte Care are enrolled and retain their coverage.

RI PRAMS continued to survey women two to four months after delivery and asked about their baby's health insurance status. The TWOS survey also includes questions regarding health insurance. Data from the National Survey of Children's Health were also analyzed to determine insurance coverage among children in Rhode Island.

One recommendation made by the Rhode Island Task Force on Premature Birth included supporting state policies and programs that ensure access to comprehensive primary and preventive health care services for women and children, specifically that RIte Care eligibility standards for children, parents, and pregnant women and RIte Care's comprehensive benefits package should be preserved. An income-based family planning waiver to enable low-income women to obtain family planning services is also recommended.

The Office of Primary Care and Rural Health conducted a survey of Primary Care Physicians statewide, to identify areas of underservice and gather information on access to care for uninsured and underinsured populations, particularly low-income and minority populations. The Office managed legislative grants made to RI Community Health Centers to defray uncompensated care costs due to increases in uninsured populations.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Administer the toll-free, bilingual Family Health Information Line, which refers families without health insurance to RIte Care and/or Family Resource Counselors in their community			X	
2. Support culturally diverse parent consultants to provide information about RIte Care at health fairs and in schools, child care settings, community-based agencies, and other forums			X	
3. DCFHE programs, including WIC, the First Connections Program, school-based health centers, Child Care Support Network and others will refer uninsured children and families to RIte Care		X		
4. Provide technical assistance to CATCH projects and community coalitions that are working at the local level to build the capacity of medical homes and link children and families to needed health and human services				X

5. Continue to participate on committees and coalitions working to increase insurance coverage among Rhode Islanders				X
6. Collect and analyze data from PRAMS on the health insurance status of new mothers and their children				X
7. Collect and analyze data from TWOS on the health insurance status of mothers and their children				X
8. Administer the PPEP that provides direct assistance to families in accessing and retaining health insurance.			X	
9. Support the RI Task Force on Premature Birth to implement recommendations to reduce the rate of prematurity in Rhode Island				X
10. Child care health consultants will assist child care providers to ensure that children in their care are linked with Rite Care		X		

b. Current Activities
Family Health Information Line Information Specialists and parent consultants receive training in RIte Care.

DCFHE programs refer families to FRCs/ RIte Care/Medicaid include: PPEP, SBHCs, WIC First Connections Program and the Child Care Support Network.

DCFHE programs provide technical assistance to local CATCH projects/coalitions to build the medical home capacity and link children/families to health services.

The DCFHE supports the Governor's Health Care Initiative by focusing on medical homes /primary care, and supports Covering Kids Rhode Island.

PRAMS and TWOS survey data continues to be collected and analyzed..

DCFHE staff partner with RI's Medicaid office in the RI's Global Medicaid Demonstration.

The RI Task Force on Premature Birth continues to monitor legislation dealing with access to health care for women of childbearing age and their children and continues to support policy and legislation through letters of support and/or opposition.

The OPCRH solicits, reviews, and recommends requests for health care safety net sites to be approved as National Health Service Corps clinician service sites, expanding access to care for uninsured populations and supporting the RI health care safety net clinical workforce as well as site visits and HPSA score updates as necessary.

c. Plan for the Coming Year
DCFHE continues to ensure that eligible families are enrolled in RIte Care or other Medical Assistance programs while monitoring the impacts of implementing the Global Medicaid Demonstration and the reversal of the documentation requirements.

Family Health Information Line Information Specialists will refer callers without health insurance to RIte Care and refer them to FRCs for further assistance in completing applications. DCFHE parent consultants will provide information about RIte Care in schools and childcare centers and at health fairs and community-based organizations.

PPEP Parent Consultants will assist families in accessing health/social services, including health insurance and assist in the verification of citizenship requirements. WIC, First Connections Program, and the Child Care Support Network will also refer uninsured or underinsured families

with young children to RIte Care.

Child care health consultants will work with licensed child care providers to ensure that all of the children in their care have access to health insurance

DCFHE will continue to provide technical assistance to several existing CATCH projects and community coalitions inProvidence, Woonsocket and Westerly, RI.

The DCFHE will continue to support the Governor's Health Care Initiative, which promises to reverse the continued erosion of employer-sponsored health insurance for small businesses in Rhode Island. In addition, the DCFHE will continue as a member of Covering Kids Rhode Island.

The CHDA will continue to conduct RI PRAMS and TWOS to obtain and analyze data on children's health insurance among recent mothers and mothers of two year olds.

The RI Task Force on Premature Births will continue to monitor legislation dealing with access to health care for women of childbearing age and their children.

The OPCRH will offer Rural Health Systems Building grants to coalitions/networks in each of the four non-metro areas of the state, to expand and enhance systems of care including strengthening partnerships between health care providers and community-based supports to support increased outreach to uninsured and Medicaid-eligible populations outside urban areas. OPCRH will analyze primary care physician shortages and submit updates as needed to maintain federal Health Professional Shortage Area designations in RI, and eligibility for federal support through the Community Health Center and National Health Service Corps programs that provide access to care for uninsured populations.

Performance Measure 14: *Percentage of children, ages 2 to 5 years, receiving WIC services with a Body Mass Index (BMI) at or above the 85th percentile.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective		42.3	36.2	35.9	32.3
Annual Indicator	42.0	35.6	35.6	34.3	33.3
Numerator	4930	3826	4443	4629	4614
Denominator	11737	10753	12482	13498	13850
Data Source				WIC Database	WIC Database
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	32.3	32.1	30.8	30.8	29.8

Notes - 2009
Percentage of WIC children with BMI >= 85th percentile appeared to decline from 34.3% in 2008 to 33.3% in 2009. It is not clear whether this decline is real or if it's due to the improvement of

data quality.

Records with missing data (age, gender, height or weight) are excluded in both numerator and denominator.

Notes - 2008
According to 2008 WIC data, 34.3% of children aged 24 to 59 months of age enrolled in the WIC Program had BMI's ge 85th percentile.
Since 2006, when the Rhode Island WIC data system changed to collect more accurate data by reducing duplicates, the percentage of WIC children who were overweight has remained stable.

Records with missing data (age, gender, height or weight) are excluded in both numerator and denominator.

Notes - 2007
Data reflects children aged 24 to 59 months old. Rhode Island's WIC data system changed in June 2006. The new system retains the same child idnum which reduces duplicates.

a. Last Year's Accomplishments
Data Discussion
RI continues to work to reduce the number of children who receive WIC services and have a BMI at or above the 85%. Recent data shows efforts are working with a decrease in this indicator from 2008 to 2009, from 35.9 to 29.4. Through ARRA funds WIC will restructure counseling to make it more client centered and easier to work with goal setting for the families including trying to achieve healthy weights. In addition, funding associated with the new food package enables counseling around reducing saturated fat intake and increasing consumption of fruits and vegetables as well as whole grains.

a. Last Year's Accomplishments

The IHW direction is outlined in its Eat Smart Move More Plan for Action 2010-2015, which includes objectives to:
· Enable and require licensed childcare menus that are consistent with the Dietary Guidelines for Americans
· Ensure coverage and capacity for nutrition counseling, behavioral counseling, and patient reimbursement of weight management program costs by RI's major health insurers.
· Promote the DHHS's Business Case for Breastfeeding and recognize worksites that effectively accommodate breastfeeding mothers.

IHW worked with the WIC Program in Central Falls and Pawtucket to increase the number of WIC vendors with access to healthy foods. WIC has implemented Value Enhanced Nutrition Assessment (VENA) and reviews staff performance through observations and trainings. Key nutrition education messages have been provided to WIC clients with implementation of the new WIC food packages. WIC continued to provide WIC sites with technical assistance and training on accurate assessments regarding overweight children. The Breastfeeding Program conducted a range of activities to educate and promote breastfeeding and provided direct breastfeeding support to women enrolled in WIC. Reduction of high BMI's is a performance measurement for WIC vendor sites.

The Farmer's Market Nutrition Program continued to offer families vouchers to buy fresh fruits and vegetables each summer. WIC partnered with Johnson & Wales University to provide nutrition education around increasing fruit and vegetable intake at local farmer's markets. WIC continued to provide nutrition information to community partners (hospitals, health centers, daycares, Early Intervention Programs) to provide consistent messages to parents and enhance communication among community partners.

During FY2009, CHDA staff worked closely with the DCFHE's IHW on issues related to data and surveillance, and analyzed data to determine trends of obesity between 2-5 year-olds participating in WIC.

The Diabetes Children Subcommittee partnered with the IHW in providing three training programs for pediatricians on counseling patients and parents about obesity, identifying patients at high risk for obesity, and diagnosing metabolic syndrome, Type 1 and 2 Diabetes in children.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Continue to implement the Initiative for a Healthy Weight RI's state plan for promoting healthy eating and active living				X
2. Support statewide breastfeeding promotion initiatives			X	
3. Provide breastfeeding support and counseling to WIC clients	X			
4. Continue pediatric provider training for obesity prevention to include BMI in captured KIDSNET data				X
5. Support the WIC Program's adoption of Value Enhanced Nutrition Assessment to provide client-focused nutrition education in response to identified risks				X
6. Administer the Farmer's Market Nutrition Program to increase WIC clients' access to and consumption of locally-grown, fresh produce		X		
7. Continue to implement and develop the functionality of the WIC Program's RI Webs computer system				X
8. Continue outreach efforts to providers to improve access to WIC and consistency of nutrition education messages				X
9. Continue to analyze WIC Program data to determine the percentage of children who are overweight and obese and to determine risk factors of and trends for obesity				X
10.				

b. Current Activities

DCFHE supports hospitals in adopting the Baby-Friendly Hospital Initiative, lactation support and promotion activities. Direct support and counseling is provided to breastfeeding WIC clients.

The WIC WEBS is improving WIC services by calculating growth charts and risk factors associated with anthropometric data, significantly improving the accuracy of risk assessments for obesity.

The Farmer's Market Nutrition Program is currently underway for summer 2010 and partnering with Johnson & Wales University for nutrition education/ cooking demonstrations.

The CHDA analyzes WIC data to determine trends of obesity between 2-5 year-olds participating in WIC. IHW is also conducting pediatric provider trainings to help providers identify overweight and obesity issues, counsel and refer patients and families.

DCFHE has convened a Health Promotion Policy Council made up of senior level, highly influential state and local decision makers to define a strategic legislative agenda that is initially addressing obesity prevention.

The IHW is conducting a web-based survey of Olneyville urban community residents to assess access to healthy foods and physical activity resources.

The Diabetes Prevention and Control Program RI Diabetes Council Work group Diabetes and Children is working on information and tools for family practice physicians and pediatricians about healthy weight and diagnosis for children with type 2 diabetes and their families.

c. Plan for the Coming Year

In FY2011, the DCFHE will continue to work to reduce childhood obesity through IHW partnerships to build infrastructure and by promoting good nutrition through the WIC and Breastfeeding programs. The IHW is funded with a grant from the Centers for Disease Control and Prevention for implementation of its state Plan, providing additional resources to support obesity prevention in the state. The IHW is a recipient of a 24-month CDC ARRA CPPW physical activity funds to implement a statewide model for integrating active living into all local planning decisions through policy and environment change.

The Health Promotion Policy Council will continue to advance a strategic legislative policy agenda to address obesity prevention, including addressing regulation of the nutrition in child care centers.

The DCFHE will continue to lead the state's breastfeeding promotion initiatives, including the Baby-Friendly Hospital Initiative and training of First Connections Program home visitors. Home visitors will begin to offer lactation visits. The DCFHE will also continue to provide support and counseling to breastfeeding WIC clients.

The DCFHE, Kids First organization, and the RI Department of Education will continue to provide technical assistance to School District Health and Wellness Subcommittees to improve school environments to support better nutrition and more physical activity.

WIC staff will continue to provide additional training on VENA and will monitor counseling strategies in the clinics.

The RI WEBS system will be enhanced to accommodate the new federal regulations concerning VENA and food package implementation..

WIC will partner with Johnson & Wales University in the Farmer's Market Nutrition Program. WIC staff will educate WIC participants about increasing fruit and vegetable consumption. WIC has authorized Farmers' Markets to accept the cash value voucher for fruits and vegetables.

The WIC Parent Consultant will continue to interview WIC participants regarding their perception of and experiences with WIC nutrition education services. This information will be shared with local WIC agencies to help them improve the nutrition education services they provide and identify staff training needs.

CHDA staff will continue to work on analyzing WIC data to determine trends of obesity between 2-5 year-olds participating in WIC.

The new Child Health Consultants will coordinate with WIC and refer children in childcare, and their families who would benefit from WIC.

The Diabetes Prevention and Control Program plans to continue through the efforts of the Diabetes and Children's Work group to coordinate with the IHW to prevent childhood obesity and the development of type 2 Diabetes.

Performance Measure 15: *Percentage of women who smoke in the last three months of pregnancy.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2005	2006	2007	2008	2009
Annual Performance Objective		11.7	11.5	12.9	11.4
Annual Indicator	11.7	13.4	12.4	10.8	11.1
Numerator	1382	1548	1432	1205	1329
Denominator	11827	11520	11542	11166	12024
Data Source				PRAMS	PRAMS
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	11	11.2	11.4	11.3	11

Notes - 2009
Data are estimated.

Data collection for 2009 PRAMS will not be completed until end of June 2010 and the weighted data for 2009 will not be available until the winter 2010.

Notes - 2008
Rhode Island PRAMS 2008.

Notes - 2007
The Confidence Interval (95% Confidence Level) for 2004 - 2007, indicate that the percentage of women who smoked in the last three months of their pregnancy remained stable.

a. Last Year's Accomplishments
According to 2009 PRAMS data, 11.4% percent of women reported smoking in their last trimester. While this is the lowest percentage since 2006, disparities still remain. Rates of smoking during pregnancy vary significantly by age, educational level, marital status, race/ethnicity, household income, and health insurance. The DCFHE continues support a variety of prevention and screening activities and will continue its efforts to reduce smoking during pregnancy, particularly among at-risk populations.

The DCFHE RI Tobacco Control Program conducts a variety of activities to prevent children from ever starting to use tobacco and helps smokers and users of smokeless tobacco quit. The Tobacco Control Program administers the toll-free telephone Quitline (1-800-Try-To-Stop), which directs smokers or those who care about smokers to the quitting program that will work best for them: an interactive website (trytostop.org), information materials, or telephone counseling.

The DCFHE supported Tobacco Control Program activities through participation on a tobacco use disparities workgroup and through integrated programming and messaging. In addition, the Department's Health Information Line referred callers with questions about smoking to 1-800-Try-To-Stop.

The DCFHE continued to support the Women's Health Screening & Referral Program (WHSRP),

which provides no-cost pregnancy testing and comprehensive health risk assessment to women receiving pregnancy-testing services in federally-funded Title X family planning clinics. Through the WHSRP, pregnant women with identified health risks were referred to prenatal care and other community-based supports early in pregnancy. Both pregnant and non-pregnant women who were screened and found to be smokers were provided with education about the hazards of smoking to their health and to that of their unborn child and were referred to smoking cessation programs.

Recommendations made by the RI Task Force on Premature Birth included urging HEALTH and other anti-tobacco organizations to incorporate messages about the risks of smoking and premature births into anti-tobacco media campaigns, including a specific focus on smoking cessation programs during pregnancy, and promoting the services of tobacco cessation services by women who smoke by marketing Quitworks to prenatal care providers and by improved identification of pregnant and soon to be pregnant smokers with referrals to Quitworks or community-based cessation providers. The RI Task Force on Premature Birth was awarded an AMCHP mini-grant to work on this issue.

The CHDA continued to conduct PRAMS and determine the percentage of respondents who reported they had smoked during the last trimester of their pregnancy.

Due to 2009 legislative action, RI has the highest cigarette tax in the nation, a proven practice that supports quitting.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Support the RI Task Force on Premature Births to identify opportunities and actions to reduce the rate of prematurity in Rhode Island				X
2. Continue efforts to strengthen the Division's current level of maternal health programming				X
3. Partner with the RI Tobacco Control Program through participation on intradepartmental workgroups and shared programming and messaging			X	
4. Continue to support the Women's Health Screening & Referral Program, which provides comprehensive health risk assessment and referral services to women in Title X sites	X			
5. . Continue to conduct RI PRAMS and analyze data on women who smoke in the last three months of pregnancy				X
6.				
7.				
8.				
9.				
10.				

b. Current Activities

HEALTH was instrumental in the development of an insurance mandate that requires health insurers in Rhode Island to cover smoking cessation treatment, supports HEALTH's Tobacco Control Program, refers Family Health Information Line callers to 1-800-Try-To-Stop, and distributes tobacco prevention and cessation materials. WIC continues to screen pregnant

women for smoking and referral to needed services.

The DCFHE continues to support the WHSRP at federally funded Title X family planning clinics. Through the WHSRP, pregnant/ non-pregnant women who smoke are provided with education about the hazards of smoking to their health and to that of their unborn child and are referred to smoking cessation programs. Women with identified health risks are referred to prenatal care and other community-based supports early in pregnancy.

The AMCHP mini-grant activities implemented by the RI Task Force on Premature Birth work group found that Rhode Island's telephone/web counseling had limited tailoring capacity to meet the needs of pregnant and postpartum women trying to quit smoking or remain tobacco free. Work is underway to build capacity to support the unique needs of pregnant and post partum women.

CHDA conducts RI PRAMS and analyzes data on women who smoke during pregnancy.

c. Plan for the Coming Year

The DCFHE will continue its efforts to reduce smoking during pregnancy, particularly among subpopulations of women with higher rates of smoking, including women with low levels of education, unmarried women, low-income women, and women from racially and ethnically diverse backgrounds.

The RI Task Force on Premature Birth will evaluate its efforts in this area and determine if more work is needed.

DCFHE will support Tobacco Control Program efforts to prevent young women from initiating smoking by using Title V funds to build state capacity to enforce laws related to tobacco sales to minors. DCFHE will continue to support the work of HEALTH's Tobacco Control Program through participation on intradepartmental workgroups and integrated programming and messaging. The DCFHE will distribute tobacco prevention and cessation materials through its programs and community partners. In addition, the Tobacco Control Program will provide training to DCFHE community partners on supporting clients in their efforts to quit smoking. Family Health Information Line Information Specialists will continue to refer callers to 1-800-Try-To-Stop.

The DCFHE will continue to support the WHSRP, which provides no-cost pregnancy testing and comprehensive health risk assessment to women receiving services in nine federally funded Title X family planning clinics. Through the WHSRP, pregnant women with identified health risks will continue to be referred to prenatal care and other community-based supports early in pregnancy. Both pregnant and non-pregnant women who are screened and found to be smokers will be provided with education about the hazards of smoking to their health and to that of their unborn child and are referred to smoking cessation programs.

DCFHE will work with the RI Department of Human Services/Medicaid to obtain additional resources to expand First Connections home visiting services to pregnant women at-risk for poor birth outcomes, including women who smoke during pregnancy.

The CHDA will continue to conduct RI PRAMS and analyze data on women who smoke during pregnancy.

Performance Measure 16: *The rate (per 100,000) of suicide deaths among youths aged 15 through 19.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	4	5.3	5	3.7	3.7
Annual Indicator					
Numerator					
Denominator	82818	81557	81557	79678	79678
Data Source				Vital Records Death File	Vital Records Death File
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.			Yes	Yes	Yes
Is the Data Provisional or Final?				Final	Provisional
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	1	1	1	1.5	1.5

Notes - 2009
Data for 2009 are provisional. For 2009 there were 2 events and a total of 9 events for 2006 thru 2009. Therefore, there are lt 5 events for the year and the average of the last 3 years is also lt 5 events.

Denominator from Populations Estimates.

Notes - 2008
For 2008 there were 4 events and for 2006 thru 2008 there was a total of only 8 events. Therefore, there are lt 5 events for the year and the average of the last 3 years is also lt 5 events.

Denominator from Populations Estimates.

Notes - 2007
For 2007 there were2 events and for 2005 thru 2007 there was a total of only 8 events. Therefore, there are lt 5 events for the year and the average of the last 3 years is also lt 5 events.

Denominator from Populations Estimates.

a. Last Year's Accomplishments
According to data from the Centers for Disease Control and Prevention, National Centers for Injury Prevention and Control. Web-based Injury Statistics Query and Reporting System (WISQARS™), in 2007 there were two deaths of youths between the ages of 15 and 19 from suicide in Rhode Island. This figure represents a 50% decline from 2001 during which there were 4 deaths among this age group from suicide. The suicide rate in Rhode Island is considerably lower than the national suicide rate for this age group: according to WISQARS™, nationally the death rate for youths ages 15 to 19 decreased from 7.94 per 100,000 in 2001 to 6.91 per 100,000 in 2007, and the Rhode Island death rate has decreased during this time period from 5.26 in 2001 to 2.50 in 2007.

The DCFHE continued to work to eliminate self-induced, preventable morbidity and mortality among youth ages 15-19 years.

DCFHE Safe RI-Violence and Injury Prevention Program secured SAMHSA funding to support a youth suicide prevention initiative which

· Trains school personnel, clinicians, parents and staff of CBO's to recognize the signs of mental illness depression and other risk factors for suicide and refer students to helping resources using QPR.
· Implements AFSP Interactive Screening Program at URI, PC, and Brown University.
· Includes suicide prevention in Brown University Medical School and Masters of Public Health curricula.
· Increases awareness and de-stigmatizes help seeking.

DFCHE partnered with Rhode Island Student Assistance Services (RISAS) as the main vendor providing easy access to highly trained counselors in schools where mental/emotional health and substance use related risk factors, such as depression, anxiety, drinking at an early age, poor academic performance, deviant school behavior, and poor parent child relationships are more likely to be detected.

The Women's Health Screening & Referral Program (WHSRP) provided no cost pregnancy testing and comprehensive health risk assessment and referral services to teens in Title X family planning sites. Teens identified with mental health concerns were referred to appropriate mental health assessment and/or treatment services.

The DCFHE Office of Special Health Care Needs (OSHCN) added a disability indicator to the Youth Behavior Risk Survey (YRBS) to enable comparison of YSHCN with their typical peers. Data demonstrated that YSHCN engage in significantly riskier behaviors and experience more depression than their peers. The OSHCN made this data available to several intervention providers and educators. DFCHE also included a sexual orientation question and analysis of that data revealed significant differences in most of the health risks. DFCHE participated in the LGBTQQ Task Force to support best practices related to these health risks.

The DCFHE managed thrive, in partnership with the RI Department of Education. This partnership focused on strengthening the statewide infrastructure to address school guidance, counseling, and social services; school environment; and school climate to assure safe, caring, and nurturing schools.

DCFHE personnel continue to participate on the Child Death Review Team led by the State Medical Examiner, which reviews child deaths to determine whether they were preventable. Suicides are included in these reviews. CHDA analyzed Vital Statistics death file data to track the rate of suicides among teens.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Fully implement the Youth Action Research to provide opportunities for youth to provide input into DCFHE programs and conduct research and make recommendations for youth violence and suicide prevention				X
2. Implement SAMHSA funded Youth Suicide Prevention and Early Intervention Program to provide gatekeeper training in				X

school, university and community agency settings and incorporation of youth suicide prevention into the Brown University medical school				
3. Support the Women's Health Screening & Referral Program to provide comprehensive health risk assessment to teens and refer teens in need of mental health services to appropriate resources	X			
4. Support the RI Task Force on Premature Birth to implement recommendations to reduce the rate of prematurity in Rhode Island.				X
5. Identify empowerment and leadership activities for youth with special healthcare needs.			X	
6. Actively participate on a suicide prevention task force and in the violence and suicide prevention project to mobilize support for violence and suicide prevention				X
7. Continue to develop the partnership with the RI Department of Education to address issues related to health and academic achievement.				X
8. Participate on the Child Death Review Team, led by the state Medical Examiner, which reviews all child deaths in the state to determine if they were preventable				X
9. Define and measure medical home models for teens and young adults				X
10. Conduct and analyze data from the YRBS on issues related to suicide (intent, attempts, etc.)				X

b. Current Activities

The Women's Health Screening & Referral Program (WHSRP) continues to provide no cost pregnancy testing and comprehensive health risk assessment and referral services to teens in Title X family planning sites. Teens identified with mental health concerns continue to be referred to appropriate mental health assessment and/or treatment services.

The DCFHE SafeRI Violence and Injury Prevention Program continues to implement the Garrett Lee Smith Memorial Youth Suicide Prevention and Early Intervention Program.

DCFHE participates on the Child Death Review Team, and analyzes Vital Statistics death files. YRBS data tracks teen suicide rates, and related indicators. OSHCN disseminates the results of the YRBS data reports to policy makers, educators, and adolescent service providers.

DCFHE in partnership with the RI Association of School Principals is developing a mental health toolkit aligned with professional development being offered to school administrators.

DFCHE and CHDA participated with RIDE on the development of a new school based survey for students, teachers and parents, to measure teaching and learning influences in RI schools. The DCFHE continues to manage thrive, in partnership with the RIDE.

The DCFHE supported Woonsocket CATCH and Washington County Coalition for Children CATCH on adolescent medical home projects.

c. Plan for the Coming Year

The DCFHE will continue to work to eliminate self-induced, preventable morbidity and mortality among teens through its partnerships on school age and youth programming.

The DCFHE will continue to support the Youth Action Research program to explore strategies to engage youth action research to address issues related to poor health outcomes around sexual risk taking, substance use, violence, and mental/behavioral health.

The WHSRP will continue to provide health risk assessment to teens at Title X clinics and refer teens in need of mental health services to appropriate resources.

The DCFHE SafeRI Violence and Injury Prevention Program will expand implementation of the SAMHSA grant to address teen suicide prevention reaching non-core MCH planning cities that have high rates of teen suicide, East Providence and Cranston. The program will be expanded to identify young veterans and young people on active military duty and to reach young people in the RI Training School. A media campaign supporting this effort will also be implemented in participating cities.

The DCFHE will also continue leading the state suicide prevention task force.
The DCFHE will continue to participate on the Child Death Review Team. The DCFHE will continue to analyze data from Vital Statistics death files and the Youth Risk Behavior Survey.

The OSHCN will continue to review youth engagement and risk behavior to assess the specific needs of youth with special health care needs. The Office will continue to provide youth opportunities for healthy development, acquiring coping skills and increasing protective factors in youth with special health care needs.

The DCFHE adolescent medical home workgroup will continue to work to identify new models of teen medical homes, which include mental/behavioral health services. The DCFHE will continue to work with the Woonsocket CATCH project to complete a plan for adolescent medical homes. DCFHE will also continue to support the Washington County Coalition for Children's efforts around teen pregnancy prevention.

DCFHE will partner with pediatricians, school leaders and other stakeholders to include mental health screening tools in school and community settings.

DCFHE will continue to work with the RI Association of School Principals and the RI AAP on strategic activities to link the work of the two organizations to support health and academic achievement among school aged children.

Conduct and analyze the YRBS to collect information on issues related to suicide (intent, attempts, etc.)

The DCFHE will continue to manage thrive, in partnership with the RI Department of Education and identify opportunities within Title IV and other appropriate funding sources to support children's mental health.

Convene state level stakeholders in mental health to develop a plan to support children ‘s mental health including access and capacity, and define the role of public health in children's mental health in Rhode Island.

Performance Measure 17: *Percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonates.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2005	2006	2007	2008	2009
Annual Performance Objective	93.5	94.2	94.2	92.8	94.5
Annual Indicator	90.6	91.8	92.5	93.6	92.6
Numerator	173	168	198	161	174
Denominator	191	183	214	172	188
Data Source				Vital Records Birth File	Vital Records Birth File
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	94.5	95	95	95	95.6

Notes - 2009
Data reflects VLBW babies born in Rhode Island hospitals to Rhode Island residents. Hospital of birth is not entered for Rhode Island resident births occurring out-of-state.

Notes - 2008
Data reflects VLBW babies born in Rhode Island hospitals to Rhode Island residents. Hospital of birth is not entered for Rhode Island resident births occurring out-of-state.

Notes - 2007
Data for 2007 indicate a slight increase in the number of VLBW babies
born in high-risk facilities.

Data reflects VLBW babies born in Rhode Island hospitals to Rhode Island residents. Hospital of birth is not entered for Rhode Island resident births occurring out-of-state.

a. Last Year's Accomplishments
Women & Infants Hospital is the regional perinatal center for Rhode Island and all of southeastern New England and serves as the primary location for high-risk deliveries. From 2004-2008 more than 93 % of high-risk deliveries occurred at the center. In 2009, the percentage exceeded past years at 94.5%.

The Neonatal Intensive Care Unit (NICU) at Women & Infants' Hospital in Providence, RI serves as the sole Level III NICU in Southeastern New England. The NICU provides care for newborn infants with significant medical problems. The majority of infants admitted to the NICU are low birth weight, premature infants. The NICU employs a complement of consultants in all of the pediatric subspecialties and experienced specialists in respiratory therapy, nutrition, infant development, social services, and case management.

The DCFHE is committed to ensuring that high-risk mothers deliver at Women & Infants' Hospital so that appropriate, comprehensive, and expert care can be provided through the NICU. In 2006, approximately 92% of very low birth weight infants were delivered at Women & Infants' Hospital.

The DCFHE continued to support the Women's Health Screening & Referral Program (WHSRP), which provides no-cost pregnancy testing and comprehensive health risk assessment to women receiving pregnancy-testing services in federally funded Title X family planning clinics. Through

the WHSRP, pregnant women with identified health risks were referred to prenatal care and other community-based supports early in pregnancy.

A RI Task Force on Premature Birth recommendation focused on developing a coordinated medical home for preterm infants and their families at Women & Infants Hospital's NICU. Another recommendation focused on implementing changes to the vital statistics birth record to include: methodology used to calculate gestational age and use and type of fertility treatment to achieve pregnancy.

The First Connections Home Visiting Program offered services on a limited basis to at-risk pregnant women and connected them to prenatal care and other community resources.

A pediatric developmental physician worked as a consultant for the DCFHE at the Hasbro Children's Hospital Children's Neurodevelopmental Center providing training to personnel at the Women & Infants' NICU to help ensure that high-risk infants were referred to the Early Intervention Program prior to discharge. In Rhode Island, very low birth weight is considered to be a "single established condition", and as such, these babies are automatically eligible for Early Intervention services. Physician materials developed by the DCFHE for the Early Intervention Program were provided to NICU staff with information on the other risk factors that make a child eligible for Early Intervention.

The DCFHE placed a Pediatric Practice Enhancement Project (PPEP) Parent Consultant in the Women and Infants' NICU. The parent consultant reviews community resources available to families upon discharge and provides training to NICU personnel to help ensure that high-risk infants are linked to the Early Intervention Program.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Support the RI Task Force on Premature Birth to implement recommendations to reduce the rate of prematurity in Rhode Island				X
2. Continue to support the Women's Health Screening & Referral Program, which provides comprehensive health risk assessment and referral services to women in Title X sites	X			
3. Continue efforts to expand the capacity of the First Connections Home Visiting Program to provide home-based education, support, and referrals to at-risk pregnant women		X		
4. Support a parent consultant at the Women & Infants' Hospital Neonatal Intensive Care Unit to assist parents in accessing community resources, including the Early Intervention Program		X		
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

The WHSRP continues to provide no-cost pregnancy testing and comprehensive health risk assessment are referrals to women receiving pregnancy testing services in nine federally funded Title X family planning clinics.

WIHRI implemented the CHIP (Comprehensive Health Integration for Premies) Program, a specialized care program to transition NICU graduates into primary care focused on high-risk very-low birth weight infants (less than 1,500 grams) with complex special health care needs. Project outcomes include decreasing the rates of emergency room visits and re-hospitalizations.

The new birth certificate worksheet, which includes fertility questions is being implemented.

The RI Nurse Family Partnership Initiative was funded in 2008 through the federal Administration for Children and Families. One hundred high-risk first time parents are served.

The DCFHE is exploring an intensive home visiting model as well as prenatal home visiting through the First Connections.

A Pediatric Practice Enhancement Project (PPEP) Parent Consultant is supported at the Women and Infants' NICU to review community resources available to families upon discharge and provides training to NICU personnel to help ensure that high-risk infants are linked to the Early Intervention Program. Physician materials developed by the DCFHE continue to provide NICU staff with information on the other risk factors that make a child eligible for Early Intervention services.

c. Plan for the Coming Year

The DCFHE will continue efforts to ensure that high-risk mothers and newborns are provided the appropriate level of care to support their unique needs. The NICU at the Women & Infants' Hospital will continue to provide Level III subspecialty care to these women and their newborns.

The DCFHE will continue to support the WHSRP, which provides no-cost pregnancy testing and comprehensive health risk assessment to women receiving services in federally-funded Title X family planning clinics. Through the WHSRP, pregnant women with identified health risks will be referred to prenatal care and other community-based supports early in pregnancy.

The RI Task Force on Premature Birth will work with WIHRI to identify and implement strategies to support the progress of the CHIP Program through advocacy for sustained funding.
The Task Force will analyze data resulting from reprogramming the electronic birth record to capture gestational age documentation and methodology on the obstetrician's worksheet.

The DCFHE will assist Rhode Island Kids Count and the Nurse Family Partnership Implementation Site to apply for funding to expand the initiative in Rhode Island

The PPEP Parent Consultant working in the NICU will continue to provide assistance to families in accessing community resources and will provide training to NICU personnel to help ensure that high-risk infants are linked to the Early Intervention Program prior to discharge.

Performance Measure 18: *Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	90.2	89.4	85	82.5	84.5
Annual Indicator	89.8	84.5	82.0	81.9	85.2
Numerator	10541	10211	9910	9539	9469

Denominator	11744	12086	12083	11651	11117
Data Source				Vital Records Birth File	Vital Records Birth File
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	85.4	85	85	85	85

Notes - 2009
Data reflect calendar year 2009 and are provisional.

Notes - 2008
Data for 2008 reflects calendar year.

The decline in infants born to pregnant women receiving prenatal care beginning in the first trimester began in 2006. Starting in 2006, the source for Month Prenatal Care Began, changed from mother's work sheet (self-reported) to OB chart provided to hospitals of birth.
Birth records with unknown or missing 'month of prenatal care' are excluded from the denominator.

Notes - 2007
Data for 2007reflects calendar year.

Starting in 2006, source for Month Prenatal Care Began, changed from mother's work sheet [self-reported] to OB chart provided hospital of birth.

Birth records with unknown or missing 'month of prenatal care' are excluded from the denominator.

a. Last Year's Accomplishments
According to PRAMS data, the percentage of infants born to pregnant women receiving prenatal care beginning in the first trimester has increased from 82.5% in 2008 to 84.5% in 2009. After a downward trend from 91.8 % in 2004 to 82.5% in 2008, this is promising information. Disparities remain among sub-populations; the DCFHE will continue to support integrated efforts that ensure early access to care for pregnant women, with special focus on at-risk populations.

The DCFHE continued efforts to ensure that high-risk mothers and newborns are provided the appropriate level of care to support their unique needs. The NICU at the Women & Infants' Hospital will continue to provide Level III subspecialty care to these women and their newborns.

The DCFHE will continue to support the WHSRP, which provides no-cost pregnancy testing and comprehensive health risk assessment to women receiving services in federally-funded Title X family planning clinics. Through the WHSRP, pregnant women with identified health risks will be referred to prenatal care and other community-based supports early in pregnancy.

The DCFHE assisted Rhode Island Kids Count to apply for funding through the federal Administration for Children and Families for the Nurse Family Partnership Program, a five year systems building initiative for first time at risk parents in Rhode Island.

The PPEP Parent Consultant working in the NICU continued to provide assistance to families in accessing community resources and provided training to NICU personnel to help ensure that high-risk infants are linked to the Early Intervention Program prior to discharge.

Miriam Hospital of Rhode Island (a Ryan White HIV Care provider funded by DCFCHE), provided 100% of the HIV infected pregnant women with AVR therapy.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Continue to support the Women's Health Screening & Referral Program to provide comprehensive health risk assessment and referral services to women in Title X sites	X			
2. Continue efforts to increase of the capacity of the First Connections Program to provide at-risk pregnant women with home-based education, support, and referral to services		X		
3. Continue efforts to increase of the capacity of the First Connections Program to provide at-risk pregnant women with home-based education, support, and referral to services				
4. Continue to collect Newborn Developmental Risk Screening data to determine the adequacy of prenatal care			X	
5. Continue to survey new mothers on the adequacy of prenatal care through PRAMS				X
6. Support the RI Task Force on Premature Birth to implement recommendation to reduce the rate of prematurity in Rhode Island.				X
7. Continue to work with CATCH grant community partnership coalitions to increase the rate of entry into prenatal care in the first trimester				X
8. Support the RI Task Force on Premature Birth to implement recommendations to reduce the rate of prematurity in Rhode Island				X
9.				
10.				

b. Current Activities

The Women's Health Screening & Referral Program (WHSRP) continues to provide no-cost pregnancy testing /comprehensive health risk assessment to women receiving services in Title X family planning clinics with referrals made to prenatal care/community-based supports early in pregnancy.

The RI Task Force on Premature Birth developed a "Guideline of the Month" focusing on the indications for uses of 17-OHP in preventing preterm birth. The Guideline was highlighted for three months, through WIHRI.

The toll-free Family Health Information Line continues. Bi-lingual information specialists provide answers/refer callers to resources. Culturally/linguistically appropriate informational materials are distributed.

The CHDA continues to administer the PRAMS survey, and Newborn Developmental Risk Screening data are collected/analyzed regarding the adequacy of prenatal care among pregnant women.

DCFHE supported the Washington County Coalition for Children's Westerly CATCH project to develop and implement as assessment that focused on delayed prenatal care, teen pregnancy and food insecurity.

The RI Nurse Family Partnership Initiative continued with funding from the federal Administration for Children and Families. One hundred high-risk first time parents were served.

Miriam Hospital of Rhode Island (a Ryan White HIV Care provider funded by DCFCHE), provided 100% of the HIV infected pregnant women with AVR therapy.

c. Plan for the Coming Year

The DCFHE will continue to support programming that ensures early access to care for pregnant women, with a special focus on at-risk populations.

The DCFHE will continue to support the Women's Health Screening & Referral Program (WHSRP), which provides no-cost pregnancy testing and comprehensive health risk assessment to women receiving pregnancy testing services in Title X family planning clinics. Through the WHSRP, pregnant women with identified health risks are referred to prenatal care and other community-based supports early in pregnancy.

The DCFHE is applying for the HRSA Maternal, Infant and Early Childhood Home Visiting Programs to establish a prenatal home visiting component through First Connections.

The DCFHE will continue to support the toll-free Family Health Information Line, which is a statewide resource for all families in RI. Bi-lingual information specialists answer questions and refer callers to appropriate community resources. Culturally and linguistically appropriate informational materials will be distributed through the Division's centralized distribution center.

Newborn Developmental Risk Screening data will be collected and analyzed to determine the adequacy of prenatal care. In addition, the DCFHE will continue to work with the CHDA to track rates of prenatal care using multiple sources, including PRAMS and vital records.

DCFHE will continue to support Washington County Coalition for Children's Westerly CATCH project to develop strategies based on community assessment findings to increase the rate of entry into prenatal care in the first trimester.

Miriam Hospital of Rhode Island (a Ryan White HIV Care provider funded by DCFCHE, continues to work to ensure that HIV-infected pregnant women received AVR therapy.

D. State Performance Measures

State Performance Measure 1: *Percent of PRAMS population who had a diagnosis of depression before or during pregnancy.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective		15.2	15.2	13.7	14.2

Annual Indicator	12.4	14.6	14.2	14.2	14.2
Numerator	1465	1653	1627	1568	1568
Denominator	11802	11334	11452	11024	11024
Data Source				PRAMS Survey	PRAMS Survey
Is the Data Provisional or Final?				Provisional	Provisional
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	13.2	13.2	13.2	13.5	

Notes - 2009
Since collection of PRAMS surveys for 2009 is not yet complete, 2009 data are estimate. It is estimated that data will show trend to remain about the same. Data for 2009 will be updated when final file is received

Notes - 2008
The Confidence Interval (95% Confidence Level) for 2005 - 2008 indicate that the percent of women who had a diagnosis of depression before or during pregnancy remained stable.

Notes - 2007
The Confidence Interval (95% Confidence Level) for 2004 - 2007, indicate that the percent of women who had a diagnosis of depression before or during pregnancy remained stable.

a. Last Year's Accomplishments
This is the final year that Rhode Island will report on this State Performance Measure.

The DCFHE is committed to protecting and promoting the health of women across the reproductive lifespan. Research has shown that approximately one in five women experience perinatal depression and that these women are at a higher risk for poor birth outcomes. Identifying women with depression and facilitating access to services is a priority for the DCFHE. In addition, understanding characteristics and experiences of women suffering from depression informs program enhancements and policies, both within the DCFHE and among external partners.

The DCFHE continued to support the Women's Health Screening & Referral Program (WHSRP), which provides no-cost pregnancy testing and comprehensive health risk assessment to women receiving services in Title X family planning clinics. Through the WHSRP, pregnant women with identified health risks were referred to prenatal care and other community-based supports early in pregnancy. Both pregnant and non-pregnant women who were screened and found to be at-risk for depression were provided with a referral for mental health follow-up. Rhode Island's capacity to provide needed mental health services to uninsured individuals is limited, however.

As part of the Newborn Screening Program, all infants born in RI are screened for developmental risk factors at the birthing hospital (called Level I screening). Level I screening includes a risk criterion related to caregiver mental health. Families of at-risk infants were offered home visits subsequent to hospital discharge through the First Connections Program providing home-based outreach, education, referral, and follow-up for at-risk pregnant women and families with young children. The program employs registered nurses, social workers, and paraprofessionals. Services offered include child, family, and home assessments and linkages to resources and services in the community.

Implementation of the Successful Start Strategic Plan, a plan designed to create a more effective and coordinated system of early childhood services continued. The Plan contains several elements related to identifying maternal mental health concerns, including implementing an intensive home visiting program and working in pediatric primary care offices to identify maternal mental health concerns. DCFHE staff continued to provide technical asssisntance to physicians offices to screen women with young children for depression.

The DCFHE continues to survey recent mothers to determine the percentage of respondents who reported a diagnosis of depression before or during their pregnancy. During 2006, 11.6% of PRAMS respondents reported they had been diagnosed with depression before their pregnancy and 9.4% had been diagnosed with depression during their pregnancy. Approximately, two out of three (66.0%) respondents who were diagnosed with depression before their pregnancy were taking prescription medications for their depression before they became pregnant. Nearly half (49.8%) of the respondents who were diagnosed with depression during their pregnancy were taking prescription medications during their pregnancy; and nearly three quarters (72.4%) of these women were provided information about the risks and benefits of taking these medications during pregnancy. More than half of the respondents indicated they had received counseling for their depression before they became pregnant (55.4%) and during their pregnancy (55.1%).

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Implement strategies and recommendations to strengthening DCFHE maternal health programming to address the health needs of women of reproductive age				X
2. Continue to support the Women's Health Screening & Referral Program to provide comprehensive health risk assessment and referral services to women in Title X sites	X			
3. Continue to screen all newborns for developmental risk factors, including a history of caregiver mental health issues			X	
4. Provide high-risk pregnant women and families of young children with First Connections Program home-based outreach, education, referral, and follow-up services		X		
5. Expand elements of the Successful Start Early Childhood Systems Plan related to maternal mental health, including maternal depression screening and provider training				X
6. Screen for maternal depression and promote maternal mental health through RI LAUNCH				X
7. Continue to conduct RI PRAMS to collect and analyze data on maternal depression				X
8.				
9.				
10.				

b. Current Activities

The Women's Health Screening & Referral Program continues to provide free pregnancy testing/comprehensive health risk assessment for women at Title X family planning clinics. Both pregnant and non-pregnant women who are screened and found to be at risk for depression are provided with a referral for mental health follow-up. Rhode Island's capacity to provide needed mental health services to uninsured individuals continues to be limited.

At birthing hospitals, newborns receive developmental risk screening with one risk criterion related to caregiver mental health. Families of at-risk infants are offered home visits through the First Connections Home Visiting Program.

With community/ health care partners, Successful Start promotes maternal mental health thru a model of community-based developmental/behavioral screening of young children in medical homes/child care settings. It includes screening for maternal depression (implemented in primary care practices only).

Mothers continue to be surveyed to determine the percentage of respondents reporting a diagnosis of depression before or during their pregnancy and their associated risk factors.

Strategies include educational materials for use with the Family Health Information Line and immigrant populations; expanded use of the WHSRP tool in private practices; alternative strategies to meet women's mental health needs and supports for women with disabilities.

c. Plan for the Coming Year
The DCFHE will continue its efforts to promote and protect the health of women across the reproductive lifespan.

The DCFHE will continue to support the WHSRP to provide pregnancy testing and health risk assessment to women receiving services in nine Title X family planning clinics. Both pregnant and non-pregnant women who are screened and found to be at risk for depression will continue to be referred for mental health follow-up.

DCFHE will seek support in the way of grants and partnerships to implement priorities around maternal health including developing educational materials for use with the Family Health Information Line; developing educational tools for immigrant populations; exploring the feasibility of expanding use of the WHSRP tool in private practices; developing alternative strategies to meet the mental health needs of women; and developing supports for women with disabilities; and training health care providers in providing confidential services.

All newborns will continue to be screened for developmental risk factors at the birthing hospital. Level I screening includes a risk criterion related to caregiver mental health. These risk criteria will be updated to reflect the best research around determining maternal mental health. Families of at-risk infants will continue to be offered home visits through the First Connections Home Visiting Program.

Successful Start will continue to expand and evaluate elements of the Early Childhood Systems Plan related to promoting maternal mental health. In collaboration with the RI AAP and others, a model of community-based developmental screening and referral to services will be expanded beyond the pilot communities and evaluated in several communities.

Project RI LAUNCH will continue to provide mental health consultation to primary care providers who serve families with young children. As part of this consultation screening for maternal depression will be incorporated.

The DCFHE will continue to conduct PRAMS among recent mothers two to six months after delivery and data will continue to be analyzed to determine the percent of respondents who reported a diagnosis of depression before or during their pregnancy.

State Performance Measure 2: *Percent of children aged 2-5 enrolled in the WIC Program with BMI's >=95th percentile*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2005	2006	2007	2008	2009
Annual Performance Objective		23.2	18.2	17.7	17.2

Annual Indicator	18.7	17.2	17.4	17.2	16.2
Numerator	2195	1854	2167	2318	2250
Denominator	11750	10753	12482	13498	13850
Data Source				WIC Database	WIC Database
Is the Data Provisional or Final?				Final	Provisional
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	17.2	17.2	17	16.8	

Notes - 2009
Percentage of WIC children with BMI >= 95th percentile appeared to decline from 17.2% in 2008 to 16.2% in 2009. It is not clear whether this decline is real or it is due to improvement of data quality.

Records with missing data (age, gender, height or weight) are excluded in both numerator and denominator

Notes - 2008
According to 2008 WIC data, 17.2% of children aged 24 to 59 months of age enrolled in the WIC Program had BMI's ge 95th percentile.
Since 2006, when the Rhode Island WIC data system changed to collect more accurate data by reducing duplicates, the percentage of WIC children who were overweight has remained stable.

Records with missing data (age, gender, height or weight) are excluded in both numerator and denominator.

Notes - 2007
Data reflects children aged 24 to 59 months old. Rhode Island's WIC data system changed in June 2006. The new system retains the same child idnum which reduces duplicates

a. Last Year's Accomplishments
This is the final year that Rhode Island will report on this State Performance Measure.

In 2007, 17.36% of children aged two to five enrolled in WIC had a Body Mass Index greater than the 95th percentile; this is compared to 2006 data at 17.24%. Preventing obesity among all Rhode Islanders continues to be one of the five priorities of the Director of HEALTH. The Department's activities related to obesity are spearheaded by the DCFHE's IHW.

DFCHE and the RIDE continue to work with District Health and Wellness Subcommittees to address childhood obesity in the school community setting.

In addition to working with the Initiative for a Healthy Weight to support infrastructure building, the DCFHE also supported activities to prevent childhood obesity through the WIC Program. WIC continued with implementation planning for Value Enhanced Nutrition Assessment (VENA). The WIC Program continued discussions regarding upcoming changes with respect to VENA with WIC staff. Tools to help staff assess the needs of the clients in WIC were fine-tuned. The State WIC Program began using the Touching Hearts Touching Minds education materials developed in Mass. Through site visits, WIC staff has continued to provide feedback and training on how to accurately assess children and counsel parents/caretakers of overweight children. WIC developed and distributed several new education materials for WIC participants including counseling on the topic of obesity and age-specific feeding and activity guides

WIC continued to support the Farmer's Market Nutrition Program to offer families vouchers to buy fresh fruits and vegetables each summer. In FY2007, WIC again partnered with Johnson & Wales University to provide nutrition education around increasing fruit and vegetable intake at local farmers' markets.

RI Webs continued and has helped improve and enhance nutrition assessment procedures and data collection, significantly decreasing inaccurate risk assessments and improving assessments for obesity.

The Breastfeeding Program continued to conduct a range of activities to educate and promote breastfeeding and provided direct breastfeeding support to women enrolled in WIC.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Continue to partner with the Initiative for a Healthy Weight in developing and implementing RI's state plan for promoting healthy eating and active living				X
2. Support statewide breastfeeding promotion initiatives			X	
3. Provide technical assistance and support to school district Health and Wellness Subcommittees				X
4. Provide funding and technical assistance to six communities to develop guidelines, environmental supports, and programs that promote healthy eating and active living				X
5. Support the WIC Program's adoption of Value Enhanced Nutrition Assessment to provide client-focused nutrition education in response to identified risks				X
6. Administer the Farmer's Market Nutrition Program to increase WIC clients' access to and consumption of locally-grown, fresh produce		X		
7. Continue to implement and develop the functionality of the WIC Program's RI Webs computer system				X
8. Continue outreach efforts to providers to improve access to WIC and consistency of nutrition education messages				X
9.				
10.				

b. Current Activities

Efforts to increase breastfeeding among new mothers continue including sponsoring hospitals that adopt the Baby-Friendly Hospital Initiative. First Connections Home Visiting Program nurses include certified lactation consultants. Direct support and counseling is provided to breastfeeding WIC clients.

WIC continues to train for VENA implementation, monitors/trains staff on accurate and appropriate assessments for overweight children.

RI WEBS helps expedite and improve WIC services via improved and enhanced nutrition assessment procedures and more accurate obesity risk assessments. Data quality is monitored and training provided to local agency staff as needed.

The Farmer's Market Nutrition Program continues. WIC again is partnering with Johnson & Wales University to enhance onsite nutrition education with cooking demonstrations.

WIC's parent consultant continues to work at the State WIC Office and plays an important role in outreaching to providers and other community organizations regarding WIC's childhood obesity prevention efforts. The parent consultant also interviews WIC participants at local agencies to

assess their perception of the quality of nutrition services.

WIC participants are offered fresh fruits and vegetables at lower cost that the supermarkets, in Central Falls. Health Metrics evaluated 11 sites and provided recommendations to local agencies and the State around best practices for meeting the needs of the community.

c. Plan for the Coming Year

DCFHE will continue to work to reduce childhood obesity by partnering with the IHW on infrastructure building activities and by promoting good nutrition through the WIC and Breastfeeding programs. The Initiative for a Healthy Weight is partnering with WIC through a CDC grant to improve childhood obesity services through WIC. This program will be developed through our Central Falls WIC site. Rhode Island WIC will be implementing some of the recommendations provide by Health Metrics.

The DCFHE will continue to lead the state's breastfeeding promotion initiatives, including the Baby-Friendly Hospital Initiative and training of First Connections Program home visitors to offer lactation visits. The DCFHE will also continue to provide support and counseling to breastfeeding WIC clients.

The DCFHE and RIDE will continue to provide technical assistance to the school district Health and Wellness Councils.

WIC staff will continue to update and submit a VENA implementation plan in late summer 2008 to FNS that will continue to clarify our states goals and timelines for nutrition education and training strategies for local WIC agency staff on VENA.

The RI Webs computer system will continue to be monitored and used more extensively as all levels of staff become comfortable and fully competent with its use. Updates to the RI WEBS system will be done to conform to the food package regulations.

WIC will again partner with Johnson & Wales University for the nutrition education piece of the Farmer's Market Nutrition Program. WIC staff will be trained on how to educate WIC participants about increasing fruit and vegetable consumption. Johnson & Wales will partner with WIC on staff training.

Consistent messages to families will continue to encourage more effective behavior change. The WIC Parent Consultant will continue to interview WIC participants regarding their perception of and experiences with WIC nutrition education services. This information will be shared with local WIC agencies to help them improve the nutrition education services they provide and identify staff training needs.

The CHDA will continue to analyze WIC Program data to determine the percentage of children who are overweight (85th to 95th percentile) and obese (at or above the 95th percentile) and associated risk factors.

Heights and weights for WIC clients are included in KIDSNET. BMI programming in KIDSNET is planned to calculate BMI and percentiles using CDC guidelines and generate BMI growth charts. These will be available to WIC, primary care providers, and other authorized users who monitor healthy weight. Additional programming will enable KIDSNET to receive height and weight data from electronic health records when immunization data is submitted.

State Performance Measure 3: *Percent of Rhode Island resident families with at-risk newborns that received a home visit from the Family Outreach Program within the newborn period (<=90 days)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	54.5	55	55	47	55
Annual Indicator	56.4	55.8	48.2	45.3	45.6
Numerator	3894	3960	3524	3183	3122
Denominator	6902	7091	7309	7030	6840
Data Source				Universal Newborn Screening	Universal Newborn Screening
Is the Data Provisional or Final?				Final	Provisional
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	55.2	55.7	55.7	55.7	

Notes - 2009
Data reflects calendar year and the denominator includes 2,964 moms that refused a home visit.

As of April 2009 the Family outreach Program was renamed The First Connections program. Rhode Island wrote certification standards and awarded contracts to two new vendors and two previous vendors. The start up for the new vendors was slow and it has been noted that we have had an increase in refusals with the change in name as well as with the change in providers. For the first time, we used community based providers that were NOT Visiting Nurse Associations. In 2010, the program has implemented the following:
1. Careful review of the data to determine possible population/location trends in refusals and unable to locate families
2.Monthly feedback to organizations on capture rate
3. Focus groups to learn more about why families are refusing and how we can improve services
4. Grant dollars to vendors to engage in parent engagement/outreach efforts to increase home visit participation.

Notes - 2008
In 2008 the program that provides home visits to newborns and children under 3 was reconfigured and awarded through a competitive bid process to new vendors. These new vendors are serving new communities and have established relationships with many of the populations in their communities.

The denominator includes 1,254 moms that refused a home visit.

Notes - 2007
The number of Rhode Island Resident newborns who received a home visit declined in 2007 because the primary contractor providing the services [VNA Care of NE], decided to close their pediatric service division. Only children with the most significant risk profiles received visits. The capacity of the Home Visiting Program remains to be determined in 2008 due to budget constraints.

Also, the 2007 denominator includes 1923 parents that refused a home visit. Efforts are being made to understand the reasons for the refusal.

a. Last Year's Accomplishments

This is the final year that Rhode Island will report on this State Performance Measure.

Access to a broad range of health and family support services is critical to ensuring children grow into strong, healthy, productive adults. Children are at increased risk for poor development if their families experience risk factors such as inadequate income, isolation from family or friends, drug and/or alcohol abuse, mental illness, or domestic violence. Families facing multiple risk factors benefit from access to comprehensive services that build on family strengths while flexibly responding to their needs.

The First Connections Home Visiting Program is an assessment and referral program that targets children birth to age three who is at-risk for poor developmental outcomes. The program uses home visits to support families and their children by giving them the information and services they need to be as healthy as possible. Each year, nearly one-third of all families with newborns receive services from the program. The program is an integral component of the Early Intervention Program's "Child Find" outreach system. DCFHE released certification standards for the home visiting program. Four vendors applied and received awards. The model is community based. In addition, efforts were directed at identifying opportunities to improve the system of family support services in the state by expanding the capacity of evidence-based comprehensive support services for families most at risk.

The program works in conjunction with the state's universal screening program for newborns, which identifies babies with certain medical, social, or economic risk conditions. Social risk factors include: caregiver education less than 11th grade, low income, mother's age less than 19, caregiver history of a mental health condition, and many others. The databases for newborn developmental risk and home visiting are housed in KIDSNET. This creates a mechanism to track all newborns to ensure that they have been screened in the hospital.

A multidisciplinary team of nurses, social workers, and paraprofessionals provides family First Connections Home Visiting Program services. In FY2008, 54% (3,595 out of 7,322) of the families that were eligible and accepted home visits, most received between one and two visits. Services included: instruction in basic newborn care, assessments of family needs and child development, and referrals to community resources. Home visitors also serve as the follow-up for newborn metabolic and hearing screening, the Early Intervention Program, Birth Defects Program, Childhood Lead Poisoning Prevention Program, and the Immunization Program. Health care and community service providers also refer families to the program. Families may also request a home visit.

KIDSNET computer programming was modified to better track participation in the First Connections Program by risk factor.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Continue to screen all newborns for medical, social, and economic risks through newborn developmental risk screening prior to discharge			X	
2. First Connections Program home visitors will continue to serve as the follow-up for newborn metabolic and hearing screening, Early Intervention, the Birth Defects Program, Lead Program, and the Immunization Program		X		
3. The First Connections Program will continue to coordinate with and accept referrals from health care providers, community service providers, and families				X

4. Support enhanced outreach to families with multiple risk factors to facilitate increased rates of program participation		X		
5. Generate and support electronic data exchange between home visiting agencies and KIDSNET to improve the timeliness, completeness, and reliability of home visiting data				X
6. The First Connections Program will continue to be an integral component of the Early Intervention Program's "Child Find" outreach system		X		
7. Continue partnership with the RI Department of Children, Youth & Families (CAPTA) to screen children under age three who have experienced abuse or neglect for Early Intervention eligibility				X
8.				
9.				
10.				

b. Current Activities

The First Connections Home Visiting Program provides home assessments, connection to community supports, and help with child development and parenting for families of newborns identified through universal newborn developmental risk screening. First Connections Home visiting Program follow-up for newborn metabolic and hearing screening, the Early Intervention Program, Birth Defects Program, Childhood Lead Poisoning Prevention Program, and the Immunization Program. Health care/community service providers refer families to the First Connections. Families may self refer.

The First Connections collaborated with the RI Department of Children, Youth & Families to screen children under age three who have experienced abuse or neglect for Early Intervention eligibility. KIDSNET has worked with the First Connections to develop a plan for home visiting reports that will monitor participation and support the home visiting agencies.

c. Plan for the Coming Year

The First Connections Home Visiting Program will continue to provide home visiting risk and referral services to "risk-positive" newborns identified through newborn developmental risk screening. It is expected that families participating in the program will receive an average of two to three visits.

In order to improve the timeliness, completeness, and reliability of home visiting data, the DCFHE will complete specifications for electronic data exchange between home visiting agencies and KIDSNET. The DCFHE will provide technical assistance to the agencies in developing the technical specifications for the required electronic forms and in integrating the specifications into their existing electronic systems. First Connections Program vendors will use this improved data function to conduct monitoring and quality assurance activities at the agency level.

First Connections home visitors will continue to serve as the follow-up for newborn metabolic and hearing screening, the Early Intervention Program, Birth Defects Program, Childhood Lead Poisoning Prevention Program, and the Immunization Program. Health care and community service providers may also continue to refer families to the program, and families may self-refer. Services will be provided to families with significant risk factors.

HEALTH will continue to collaborate with other state agencies to implement the Nurse Family Partnership model of home visiting

The program will be continuously evaluated to identify whether or not the program is meeting its goals, if the populations most in need are being served, and how the program impacts child and family outcomes. Measures of client satisfaction will be included in the evaluation.

KIDSNET will continue to provide database and data management services for developmental risk services and home visiting. KIDSNET will also continue to generate electronic home visiting referrals based on developmental risk screening. Planned home visiting reports will be programmed in KIDSNET if resources are available.

State Performance Measure 4: *Percent of children aged less than 6 who live in the core cities and have blood lead levels at or above 10ug/dL*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	10.5	6	5	4.5	3
Annual Indicator	5.8	4.7	4.0	3.0	2.9
Numerator	916	746	611	449	402
Denominator	15664	15721	15224	14798	13907
Data Source				Rhode Island Lead Program	Rhode Island Lead Program
Is the Data Provisional or Final?				Final	Final
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	3	3	2.8	2.8	

Notes - 2009
2009: The percent of children aged less than 6 who live in the core cities and have blood lead levels at or above 10 mcg/dL, remained about the same for both 2008 & 2009.

Notes - 2008
The percent of children aged less than 6 who live in the core cities and have blood lead levels at or above 10 mcg/dL, has continued to decrease at the state and national level.
Specific, science-based reasons for the decrease are difficult to identify. It is estimated that the decrease is due to the hightened awareness about the dangers of lead in the population at large, done through local outreach efforts as well as national media, research published in a variety of channels.

a. Last Year's Accomplishments
This is the final year that Rhode Island will report on this State Performance Measure.

Severe lead poisoning can lead to mental retardation, coma, seizures and death. Even low levels of exposure can impair central nervous system function causing delayed cognitive development, hearing problems, growth retardation, and metabolic disorders. In Rhode Island, lead poisoning rates are highest among children who reside in the state's six core cities.

Over the past decade, there has been a significant decrease in the number of children afflicted with lead poisoning. In 2009, 1.6% of children less than age six residing in RI had lead levels

greater than or equal to 10mcg/dL. In addition, the percent of children living in the core cities with blood lead levels greater than or equal to 10 mcg/dL for the first time in their lives (incidence) decreased from 9.7% in 2000 to 1.8% in 2009.
The number of children entering kindergarten who have ever had an elevated blood lead level has decreased about 50% over the past few years. Of the 12,384 children who will enter kindergarten in 2011, 2.4% (302) have had a blood lead level >=10mcg/dl.

Four certified Lead Centers (supported through Medicaid funding) continued to serve lead poisoned children and their families. In 2009, the Lead Centers received 45 referrals for significantly lead poisoned children (blood lead levels > 20ug/dL), as well as 68 referrals for children with first time blood lead levels between 15 and 19 mcg/dL. In 2009, 91% of the families with a significantly lead poisoned child accepted case management services through the Lead Centers.

DCFHE continued its support of one hospital-based clinics to screen uninsured and underinsured children for lead poisoning. Lead safety remained a part of the First Connections Program home assessment protocols and home visitors collected additional information specific to the property they were visiting. The WIC Program continued to monitor lead screening among WIC-enrolled children with lead levels at or above 10 mcg/dL and continued to provide these children with nutrition counseling, education, and nutritious foods. The Immunization Program continued to include lead screening questions in its annual Immunization School Survey.

The DCFHE continued to distribute lead educational materials and provide information to families and providers contacting the Health Information Line. DCFHE staff educated providers about lead issues and staffed community health fairs and workshops. The DCFHE held the second Healthy Housing Conference in May 2010.

DCFHE continued to survey recent mothers through PRAMS (Phase V), which included questions about the age of the respondents' housing and what they are currently doing to protect their families from lead poisoning (e.g.. washing windows, doorways, floors and dusty areas; blocking chipped or peeling paint; eating calcium and iron rich foods; washing hands frequently, etc.)

Approximately 70% of children born in 2001 through 2006 were screened for lead poisoning at least once by 18 months of age. Approximately 75.5% of children born in 2006 were screened for lead poisoning at least once by 18 months of age. These high screening rates may be attributed to pediatricians' access to KIDSNET. KIDSNET allows healthcare providers to monitor lead screening among their patients and generate reports of unscreened patients in their practice at any time. In addition, physicians have been provided with additional capability to generate reports of children in their practice who have been screened for lead, but are overdue for a re-screening. Use of these reports is tracked. KIDSNET also began tracking the number of times users access the lead screening web screen.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Continue to support the Healthy Housing Collaborative and work in partnership with other state agencies and community partners to promote healthy housing for all families in Rhode Island				X
2. Continue to support one outpatient hospital-based clinic to provide lead screening to uninsured and underinsured children under age six	X			

3. In partnership with the RI Department of Human Services/Medicaid, continue to support certified Lead Centers to provide services to significantly lead poisoned children and children with first time lead levels of 15-19 mcg/dL		X		
4. Continue to collaborate with the Environmental Lead Unit to offer comprehensive home environmental lead inspections to significantly lead poisoned children.				X
5. Utilize KIDSNET data to send postcards to families with children who have not been lead screened by 18 months of age			X	
6. Monitor usage of the “never screened” and ‘overdue for screening’ lead reports available to pediatric practices participating in KIDSNET				X
7. Continue to conduct lead poisoning awareness and prevention activities as a part of "Lead Poisoning Prevention Month"			X	
8. The First Connections Program will continue to include lead safety as part of the standard assessment protocol for all families receiving home visiting services		X		
9. The WIC Program will continue to monitor lead screening in WIC-enrolled children with lead levels at or above 10 mcg/dL and provide WIC clients with counseling, education, and nutritious foods		X		
10. Continue to survey new mothers about lead topics through PRAMS				X

b. Current Activities

The Childhood Lead Poisoning Prevention Program (CLPPP) continues to convene the Healthy Housing Collaborative to develop and implement plan to create/maintain healthy housing through an eight-hour Healthy Homes training program to community health nursing students. CLPPP supports one hospital-based clinics to screen uninsured and underinsured children for lead poisoning including medical treatment.

Four lead centers provide services to lead poisoned children, as well as those with first time lead levels between 15 and 19 mcg/dL. Significantly lead poisoned children also receive an environmental lead inspection.

KIDSNET providers can generate on-demand reports of unscreened patients for quality assurance and follow-up and can generate a KIDSNET report for children who have been screened for lead but are due for a follow-up screening. Reminders to families of unscreened 18-month year olds continue. WIC staff is trained in the use of KIDSNET reports to identify and flag children with elevated lead levels.

RI celebrates May as "Lead Poisoning Prevention Month" with a Healthy Housing Conference. The First Connections Home Visiting Program assesses lead safety during all home visits.

The DCFHE continues to make progress in consolidating address info into a single statewide housing database and conducts PRAMS surveys asking new mothers about lead poisoning prevention activities.

c. Plan for the Coming Year

DCFHE will continue to monitor rates of lead poisoning among Rhode Island children. The Lead Program will continue support the Healthy Housing Collaborative and continue implementation of a statewide action plan to create and maintain healthy housing in all communities across the

state. The Childhood Lead Poisoning Prevention Program will continue to support one hospital-based clinic to screen uninsured and underinsured children under age six for lead poisoning.

The DCFHE will refer significantly lead poisoned children for home inspections and for case management through the certified Lead Centers. Children with first time lead levels of 15-19 mcg/dL will receive a referral to a Lead Center for an educational home visit. Families of children with lead levels of 10-14 mcg/dL will receive culturally and linguistically appropriate printed lead educational materials and are also offered an educational home visit by a lead center. The DCFHE will offer environmental lead inspections to families at risk of lead poisoning as identified by home visitors from the lead centers and city code enforcement staff.

KIDSNET will continue to be used as a quality assurance tool to increase and measure progress in lead screening rates statewide. Letters to parents of all 18-month-old children who have not been screened will continue to be sent on a monthly basis. Providers participating in KIDSNET will continue to have access to running a "never screened" report of their patients and an "overdue for screening" report.

The DCFHE will continue to conduct lead poisoning awareness and prevention activities, with an emphasis on primary prevention, which includes healthy homes initiatives. . The DCFHE will continue to distribute educational materials and provide information to families and providers contacting the Health Information Line.

Also in FY2010, graduate student interns will evaluate the Family Outreach and Lead Center home/environmental assessments. The intern will also create a lead screening rate 'report card' which will compare practice screening rates with other pediatric providers in comparable office settings. WIC will monitor lead screening in WIC-enrolled children with lead levels at or above 10 mcg/dL. The Immunization Program will include questions about lead screening on immunization forms utilized by schools and child care centers as a prerequisite for entry.

Child Care Support Network Health Consultants will educate and provide information to families and child care providers about the importance of lead screening and will conduct record reviews to ensure children in child care have been screened for lead.

Weighted data collected during 2004-2008 via the RI PRAMS survey on lead poisoning prevention will be analyzed.

State Performance Measure 6: *Ratio of the Black or African American prematurity rate to the White prematurity rate*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective		1.5	1.4	1.3	1.2
Annual Indicator	1.3	1.2	1.2	1.2	1.2
Numerator	13	12	12.2	11.8	11.3
Denominator	9.9	10.3	10.6	9.6	9.6
Data Source				Vital Records	Vital Records
Is the Data Provisional or Final?				Provisional	Provisional
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	1.2	1.2	1.2	1.2	

Notes - 2009
Physician's estimate and not LMP and Delivery Date are used to determine gestational age for this measure.

Also, Rhode Island implemented multiple race options in October 2008. In 2009, 20% or 2256 women selected 'other' as their race. Prior to 2009, lt 1% of women identified themselves as 'other'. The percent of women that selected 'other' among preterm births is also 20%. Despite the change in mother' race, the ratio of black prematurity rate compared to the white prematurity rate has remained around 1.3 or 1.2 since 2004.

Notes - 2008
The ratio of black prematurity rate compared to the white prematurity rate has remained around 1.3 or 1.2 since 2004.

Notes - 2007
The ratio of black prematurity rate compared to the white prematurity rate has remained around 1.3 or 1.2 since 2004.

a. Last Year's Accomplishments
This is the final year that Rhode Island will report on this State Performance Measure.

Preterm births are the leading cause of infant mortality in Rhode Island. Babies born prematurely are more likely to have complications such as breathing/lung problems, heart problems, anemia, jaundice, infections, etc. Among racial and ethnic groups, Black or African American women have the highest rate of preterm births.

The percentage of babies born prior to 37 weeks gestation or preterm has been rising in Rhode Island as in the nation.

DCFHE staffs the RI Task Force on Premature Birth to review current research, policies and practice that influence pre-maturity and make recommendation to reduce rates of pre-maturity in RI. The Task Force developed and publicly disseminated ten (10) recommendations to address the problem of preterm birth in Rhode Island. Recommendations focused on meeting the RIDE standards for comprehensive family life and sexuality education in all school districts; expanding and assuring access to emergency contraception for all women; supporting state polices and programs that ensure access to primary and preventive health care for women and children and supporting a Medicaid family planning waiver based on income; expanding the range of services in settings in which women receive health care before and between pregnancies (including pregnancy test visits) to include improved identification of health risks, health information, and targeted referrals for health risks associated with preterm birth (e.g. tobaccos use, substance abuse, mental illness, domestic violence, etc); enhancing comprehensive, relationship based family support programs, such as Early Head Start and Nurse Family Partnership, to improve outcomes for teens and their children and prevent subsequent pregnancies; developing and implementing an educational campaign for providers and patients addressing previous preterm birth; developing a coordinated medical home for preterm infants by bringing together payers, providers, and the Department of Health; implementing changes to the vital statistics birth record; urging the Department of Health and other anti-tobacco to incorporate messages about the risks associated with preterm birth and smoking; and encouraging developing of additional substance abuse treatment programs where women are not separated from their children.

The DCFHE continued to support the Women's Health Screening and Referral Program (WHSRP), which provides no-cost pregnancy testing and comprehensive health risk assessment to women receiving pregnancy testing services in nine Title X family planning clinics. Through the WHSRP, pregnant women with identified health risks were referred to prenatal care and other community-based supports before pregnancy or early in pregnancy. Addressing identified risks (such as maternal tobacco use, substance abuse, poor nutrition, previous preterm and/or low birth weight birth, previous pregnancy complications, etc.) before pregnancy or early in pregnancy can help reduce rates of preterm birth.

The WIC Program conducted outreach and education to OB/GYN offices to enhance enrollment

of eligible pregnant women in WIC early in their pregnancy (the first trimester). WIC provides nutritious foods, nutrition education, and referrals to health and other social services to its clients. WIC participation is linked to longer gestation periods, higher birth weights and lower infant mortality.

Race and gestational age data from the integrated newborn development risk assessment/electronic birth certificate were collected and stored in KIDSNET, facilitating monitoring over time and comparisons based on demographics, risk factors, and other information contained in KIDSNET.

DCFHE analyzed birth certificate data to determine the rates of prematurity among Rhode Island residents by demographic factors including race/ethnicity, geographic areas, etc. During FY 2009, vital statistics data continued to be analyzed to monitor preterm birth trends and rates by demographic and risk factors.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Continue to support the RI Task Force on Premature Births to implement recommendations.				X
2. Implement strategies for strengthening DCFHE maternal health programming to address the health needs of women of reproductive age and improve birth outcomes				X
3. Continue to support the Women's Health Screening & Referral Program to provide comprehensive health risk assessment and referral services to women receiving pregnancy tests in Title X sites	X			
4. Continue efforts to expand the First Connections Program's capacity to provide high-risk pregnant women with home-based outreach, education, referral, and follow-up services		X		
5. Collect and analyze race and gestational age data from the integrated newborn developmental risk assessment/electronic birth record				X
6. Implement Healthy Teen Projects to build neighborhood capacity to support youth				X
7.				
8.				
9.				
10.				

b. Current Activities

Monitoring and analysis of prematurity rates by gestational age, plurality, and other maternal and infant characteristics continues.

The RI Task Force on Premature Births is working to implement its ten (10) recommendations, which includes prioritizing action steps and measuring progress toward the overarching goal of reducing the rate of mortality and morbidity associated with preterm births in Rhode Island. Progress reports for each recommendation appears elsewhere in this document under the most pertinent national or state performance measure.

The Women's Health Screening & Referral Program (WHSRP) continues to provide free pregnancy testing/comprehensive health risk assessment in Title X family planning clinics. Those with identified health risks are referred to prenatal care/resources before pregnancy.

WIC continues to target OB/GYN providers for in-service training/outreach to enhance pregnant women's early access to WIC services.

c. Plan for the Coming Year

DCFHE will continue efforts to improve pregnancy outcomes for all women and reduce disparities.

The RI Task Force on Prematurity will continue to work toward implementing recommendations and action steps with the expectation that work will be completed for some in the upcoming year. It will continue to address recommendations through workgroups for each recommendation and monitoring each work group's progress.

The DCFHE will continue to support the WHSRP to provide pregnancy testing and health risk assessment to women receiving services in Title X family planning clinics. Through the WHSRP, pregnant women with identified health risks will continue to be referred to prenatal care and other community-based supports early in pregnancy.

DCFHE will seek support in the way of grants and partnerships to implement priorities around maternal health including developing educational materials for use with the Family Health Information Line; developing educational tools for immigrant populations; exploring the feasibility of expanding use of the WHSRP tool in private practices; developing alternative strategies to meet the mental health needs of women; and developing supports for women with disabilities; and training health care providers in providing confidential services.

The WIC Program will continue to target OB/GYN providers for enhanced outreach to increase the number of pregnant women that enter WIC during their first trimester of pregnancy. WIC will continue to provide local agency coordinators with quarterly statistics on how their agency compares to statewide statistics of first trimester prenatal enrollment into WIC.

Race and gestational age data from the integrated newborn developmental risk assessment/electronic birth record will continue to be collected and stored in KIDSNET, facilitating monitoring over time and comparisons based on demographics, risk factors, and other information contained in KIDSNET.

DFCHE will identify a community partner through an RFP process to implement a two healthy teen projects to build the community's capacity to support adolescents through implementation of youth development along with targeted strategies to address needs identified by each neighborhood group.

DFCHE will work with the YWCA of Northern RI to build capacity for statewide teenage pregnancy prevention efforts through the RI Alliance for Teenage Pregnancy Prevention.

The Gestational Diabetes Follow-Up Project will work with Women & Infants Hospital to increase the percentage of women from 45% to 80 % who return for their six-week OGTT and identify women who have prediabetes or diabetes. resources. A nurse coordinator and a bilingual patient navigator will assist patients in overcoming barriers.

DCFHE will use Title V funds to bring wellness activities and information to small RI worksites that employ women, youth and young adult workers.

State Performance Measure 7: *Percent of children (who have had at least one immunization from a primary care provider) with complete immunization series (4:3:1:3)and at least one lead screening by age 2*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective		55.7	53.2	50.2	40.7
Annual Indicator	53.2	51.8	49.5	49.9	48.7
Numerator	6307	6706	6164	6059	5963
Denominator	11848	12939	12460	12132	12249
Data Source				Kidsnet Data System	Kidsnet Data System
Is the Data Provisional or Final?				Final	Provisional
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	43.5	52.2	53.2	53.2	

Notes - 2009
Data for 2008 and 2009 reflect rate for a 4:3:1:2 schedule due to the shortage of Pedvax Hib.

Beginning around December 2007 shortages of Pedvax Hib began and continued in RI until April 2010. Prior to this time period RI was exclusively using Pedax Hib with a 3 dose schedule. It was necessary to defer the 3rd dose (booster dose) and eventually there was a switch to ACTHIB which requires 4 does. However, all children who had started with PEDVAX had received their 1st two doses (4 months of age), did not have an additional dose recommended during the shortage. In addition, during the switch to ACTHIB, the allocation of vaccine from CDC did not adequately account for RI's need to move from the 3 dose to 4 dose schedule.
The booster dose of vaccine was no longer deferred beginning with July 2009, however, it was decided that children who had missed their final dose, could receive the booster at their next regular office visit and not ask the providers to do a mass recall to immunize the children.

Notes - 2008
Medical Home Indicator Measure (Comprehensive)

2008: The decline of this state performance measure is due to the on going national shortage of HIB and RI Immunization Program switching to 3 doses of HIB in the later part of 2007.

These factors account for the temporary decline of the immunization rates in 2008 and will impact future years.
The rate when only 2 doses of HIB are considered is 47.6% for 2008.

All children with a most recent address of RI, who have had at least one immunization reported to KIDSNET by a Primary Care Provider are included in this measure. The numerator includes those who have had at least one lead test and completed the 4:3:1:3 (DTP, Polio, MMR, Hib) immunization series by their second birthday. This year's data includes children who were born in 2006 and turned 2 during 2008 .

Notes - 2007
Medical Home Indicator Measure (Comprehensive)
See Note for 2006 for complete description.

The numerator includes those who have had at least one lead test and completed the 4:3:1:3 (DTP, Polio, MMR, Hib) immunization series by their second birthday. This year's data includes children who were born in 2005and turned 2 during 2007 and shows only 50% of children with both the immunization series and a lead test by the second birthday.

a. Last Year's Accomplishments
This is the final year that Rhode Island will report on this State Performance Measure.

All children benefit from a medical home, that is, a regular source of health care from a primary care provider that is familiar with the child's family and medical history and developmental progress. Providers that have a regular, ongoing relationship with a family have a greater understanding of context in which the child is developing. They are more likely to partner with parents and other providers to identify all the medical and non-medical services needed to help children reach their full potential.

The DCFHE is committed to assuring that all children have a medical home and receive preventive health services, including immunizations; lead screening, and other age-appropriate services that are delivered in a culturally competent and family-centered way. Medical home building activities span a number of DCFHE programs, some of which are discussed below.

The Immunization Program continues to provide all recommended vaccines to providers, free immunizations to uninsured children, and immunization education to providers and the public. The program focusing its improvement rates on populations new to the country and state.

The Lead Program continues its efforts to ensure that all young children in RI receive a lead screening as part of pediatric well-child care. The program conducts lead poisoning awareness and prevention activities, including Lead Poisoning Prevention Month events. Through KIDSNET, reminders are sent to families of children turning one year old to remind them to request lead screening from their physician.

The First Connections Home Visiting Program continues to provide home-based education, support, and referral to families to ensure that children are connected to a medical home and other community resources.

DCFHE continued to implement the Pediatric Practice Enhancement Project (PPEP), which places parent consultants in primary and specialty care settings to assist families in accessing family-centered and coordinated services. The DCFHE also provided technical assistance to several initiatives focused on building medical home capacity in local communities, including the Newport County Healthy Communities Initiative, Washington County Coalition for Children, and Mt. Hope CATCH.

PPEP program was expanded to twenty provider sites. An analysis of PPEP was completed that included a review of claims data from one local health plan. The analysis found that children served by PPEP had decreased utilization of inpatient/intensive settings, increased utilization of home and community-based services, and that 57% had lower health care costs after becoming involved in PPEP.

The DCFHE continued to support medical home systems development in culturally diverse communities through technical assistance to the Newport County Healthy Communities Initiative, the Washington County Coalition for Children, Mt. Hope CATCH, and Pawtucket/Central Falls CATCH. These initiatives supported activities including: medical home training for providers, families, and social service agencies; RIte Care benefits training; dissemination of information on community resources; data development; and many other activities.

Successful Start continued implementation of its statewide Early Childhood Systems Plan. Several initiatives to build the capacity of medical homes are underway, including a project to integrate developmental screening of young children into medical homes and community settings.

KIDSNET staff continued to enroll all pediatric providers in KIDSNET to ensure that children are identified and linked to a medical home and appropriate support services. Individual

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Provide all recommended vaccines to providers, free immunizations to uninsured children, and immunization education to providers and the public to ensure that children in RI receive timely immunizations			X	
2. Continue to conduct lead poisoning awareness and prevention activities, including promoting lead screening as part of routine pediatric well-child care			X	
3. Provide technical assistance, consultation, and resource materials to child care providers to ensure that all children in child care are up-to-date on their immunizations and lead screenings and are linked to a medical home			X	
4. The First Connections Home Visiting Program will continue to ensure that at-risk families of newborns and young children are connected to a medical home and other community resources		X		
5. Support and expand the Pediatric Practice Enhancement Project, which places parent consultants in primary and specialty care settings to assist families in accessing family-centered and coordinated services		X		
6. Continue to provide support and assistance to existing and emerging CATCH projects and other medical home systems development initiatives in local communities				X
7. Support continued implementation of Successful Start medical home building activities, including developmental screening of young children in community-based settings				X
8. Continue to work to enroll all pediatric providers in the state in KIDSNET to ensure that all children are identified and are linked to a medical home and appropriate support services				X
9. Continue analyze KIDSNET and other data sources related to medical homes to determine an overall index or percentage of RI children who have a medical home				X
10.				

b. Current Activities

All ACIP-recommended vaccines are provided to providers free of charge. Uninsured children receive immunizations without charge to the family. Educational materials are available to providers and the public on the Department of Health's website. The program will continue to identify children who are not fully immunized through KIDSNET.

KIDSNET tracks immunization and lead screening status of children born after January 1, 1997. Providers may generate KIDSNET reports re: their patients' immunization / lead status. KIDSNET monitors providers' system usage and reports quarterly. Managed care organizations / KINSNET exchange information to enhance MCO reporting.

The Immunization Program will expand the vaccine program to include the recently licensed Tdap Vaccine for new mothers. The program will collaborate with RI's seven birthing hospitals to establish a routine Tdap vaccination program as standard of care for postpartum women.

The Child Care Support Network, health consultation is provided to childcare centers/ family childcare homes.

The First Connections Home Visiting Program provides follow-up to at-risk families. PPEP parent consultants link families, pediatric practices, and community resources.

Medical home systems development continues through technical assistance to community organizations and support of medical home training for providers, families, and social service agencies.

c. Plan for the Coming Year

Through its programming and strategic partnerships with agencies, associations, and coalitions, the DCFHE will continue to increase the number of children who have a medical home and receive routine and preventive health care services and immunizations that are delivered in a culturally-competent and family-centered way.

The RI Childhood Immunization Program will continue to provide all vaccines for all children at no cost, promote immunization awareness through distribution of patient and provider educational and resource materials will identify children who are behind on immunizations, and will promote immunization among populations new to the country and state.

The First Connections Home Visiting will continue to ensure that at-risk families of newborns and young children are connected to a medical home and other community resources.

The DCFHE will continue to support existing medical home systems development initiatives in local communities and continue to support PPEP parent consultants in creating linkages between families, pediatric practices, and community resources. PPEP parents will be trained to use KIDSNET to work with parents and medical homes assuring appropriate immunization and lead screening.

DCFHE will continue to work the Woonsocket CATCH grant coalition, to provide technical assistance and tools on adolescent medical home. DFCHE will work with the AAP to communicate and disseminate this model in other communities.

Successful Start will expand a model of developmental screening and referral to services. Screening tools and onsite assistance will be provided to pediatric offices and child care centers. If a grant application to SAMSHA is successful. The project will offer multidisciplinary training on medical home topics and will provide opportunities for relationship building between service sectors to facilitate coordinated referrals and services for families.

The CHDA will continue to gather data related to medical homes and will determine an overall index or percentage of RI children who have a medical home.

State Performance Measure 8: *Percent of at-risk newborns who live in a neighborhood or community with MCH community systems building partnerships*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2005	2006	2007	2008	2009
Annual Performance Objective		35.5	35.5	36.4	36.6
Annual Indicator	34.4	35.0	36.4	36.5	37.0
Numerator	2395	2486	2685	2580	2532
Denominator	6965	7112	7379	7076	6840

Data Source				Providence Plan	Providence Plan
Is the Data Provisional or Final?				Final	Provisional
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	36.8	37.2	37.2	37.4	

Notes - 2009
While data are estimated, the Department of Health believes that the percent of at risk newborns living in a neighborhoods with MCH partnerships has slightly increased as a result of expansion in community partnerships activities.

Notes - 2008
While data are estimated.

Notes - 2007
2007 data are estimated.

a. Last Year's Accomplishments
This is the final year that Rhode Island will report on this State Performance Measure.

Community systems building partnerships help communities assess the status of children, families, and neighborhoods and implement strategies to improve the health of their communities. The DCFHE provides assistance to communities to develop and support maternal and child health system assessment and strategic planning in high need communities in Rhode Island. The American Academy of Pediatrics and its local chapter and Area Health Education Centers (AHECs) are key partners in this work, providing financial support to CATCH projects.

DCFHE provided technical assistance to the Newport County Healthy Communities Initiative, the Mt. Hope CATCH, Pawtucket/Central Falls and Woonsocket CATCH and Washington County Coalition for Children.
These systems development initiatives continued to support community assessment and planning activities designed to increase utilization of maternal and child health services and improve medical homes. Initiative activities included: medical home training for medical providers, parents, and social service providers; RIte Care benefits training for medical providers and parents; development of local referral networks to improve care coordination; transportation advocacy; dissemination of information on care coordination resources; development of a network of health outreach workers; development of a plan to improve mental health resources for children; on-going community needs assessment; development of ways to utilize existing data on families without medical homes (i.e. local emergency room records); and project evaluation.

CATCH projects and community coalitions share their experiences in developing infrastructure to support a coherent and integrated system of care for children, including CSHCN, with other communities throughout the state and offer technical assistance. Parents participate in all phases of CATCH activities.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Provide training and technical assistance to support maternal and child health system assessment and strategic planning in local communities				X
2. Continue to work with The Providence Plan to develop and implement a data utilization training curriculum and technical				X

assistance plan				
3. Support participation of First Connections home visitors in community networks and coalitions				X
4. Continue to collect newborn risk information through universal newborn developmental risk assessment			X	
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities
The Newport County Healthy Communities Initiative, Washington County Coalition for Children, Mt. Hope CATCH, Woonsocket CATCH, and Pawtucket Central Falls CATCH and the Woonsocket CATCH support community assessment and planning activities designed to increase utilization of MCH services and improve medical homes.

The Providence Plan provides technical assistance and training to CATCH initiatives.

All First Connections Home Visiting providers are community based and participate in local networks with other agencies that provide home visits, social service agencies, local child welfare offices, Early Intervention, CEDARR Family Centers, COZ Family Centers, and child care programs to increase access/ better coordinate services.

c. Plan for the Coming Year
DCFHE will continue to provide assistance to communities to develop and support maternal and child health system assessment and strategic planning.

The Newport County Healthy Communities Initiative, Washington County Coalition for Children, Mt. Hope CATCH, Pawtucket/Central Falls CATCH, and a newly established group in the city of Woonsocket, RI will support community assessment and planning activities designed to increase utilization of MCH services, including RIte Care. Initiative activities will include: medical home training for medical providers, parents, and social service providers; development and implementation of local referral networks to improve care coordination; dissemination of information on care coordination resources; implementation of a plan to improve mental health resources for children; promotion of best practices around caring for adolescents; development of ways to utilize existing data on families without medical homes (i.e. local emergency room records); ongoing community needs assessment; and project evaluation. In addition, CATCH projects and community coalitions will increase their health education efforts directed at parents around specific topics, including asthma, diabetes, and obesity. Collaboration with RI AHEC and PPEP will continue.

Through the contract with The Providence Plan, the DCFHE will support communities in sharing their experiences in developing infrastructure to support integrated systems of care for children, including CSHCN, with other communities throughout the state. In addition, The Providence Plan will provide training and technical assistance to existing sites around conducting community assessments, developing and implementing strategic plans, and evaluating project success. The Providence Plan will also support new communities to apply for CATCH funding. The Providence Plan will continue to work with the DCFHE to develop a set of indicators to measure the impact of investment in community-based systems development initiatives.

All First Connections Home Visiting vendors will continue to be community based and participate in local networks. Through involvement at the community level First Connections Home Visiting staff will educate communities about the program and develop strategies to outreach to families who are difficult to locate.
Information on newborn risk factors will continue to be collected through universal newborn developmental risk assessment and stored in KIDSNET. DCFHE staff will begin to explore opportunities to connect KIDSNET to the Department of Health's Geographic Information System to allow for geo-coding of address information.

State Performance Measure 9: *Percent of licensed child care providers with on-site health consultants*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective		30	35	40	39
Annual Indicator		35.0	38.0	38.0	37.7
Numerator		148	162	145	155
Denominator		423	426	382	411
Data Source				Phone Survey	Phone Survey
Is the Data Provisional or Final?				Final	Final
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	40	45	45	45	

Notes - 2009
The department of HEALTH began supporting child care providers to have on site health consultants in 2007.
Results for this State Performance Measure were obtained from a phone survey conducted in December 2009. Results indicate that the percent of licensed child care providers with on-site health consultants remained the same .

Notes - 2008
The department of HEALTH began supporting child care providers to have on site health consultants in 2007.
Results for this State Performance Measure were obtained from a phone survey conducted in February 2009. Results indicate that the percent of licensed child care providers with on-site health consultants remained the same for 2007 and 2008.

Notes - 2007
Results are from a phone survey conducted of licensed child care providers in March 2008.

a. Last Year's Accomplishments

This is the final year that Rhode Island will report on this State Performance Measure.

Strong families and healthy communities provide the foundation for children's healthy development. Community-based early childhood services are part of the critical network of supports for families. An effective early childhood system addresses the needs of all children, while providing more intensive services for infants and children most at risk.

The state Title V agencies in federal Region I developed an asset-based measure of their individual early childhood health and development systems -- the percent of licensed child care

providers with onsite health consultants. Child care health consultants improve the general health and safety of children in child care and promote children's development. At this time, a region wide means to accurately measure the use of health consultants is under development.

Region 1 has a long history of working to develop and improve state's abilities to support child care health consultation. As part of the Healthy Child Care America initiative, the Region 1 states formed Healthy Child Care New England (HCCNE) in 2000. The collaborative is focused on creating and maintaining a coordinated child care health consultant training program for all six New England state. The Team Lead of the Perinatal and Early Childhood Team participates on the New England Collaborative. .

Rhode Island currently has 7 child care health consultants trained at the national training center. Training on caring for children with special health care needs and behavioral challenges, healthy and supportive environments, and caring for infants and toddlers was provided.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Continue implementation of the Successful Start Early Childhood Systems Plan				X
2. Fully implement child care health and mental health consultation to support the healthy development of children in child care			X	
3. Continue partnering with Healthy Child Care New England to offer training opportunities for child care health consultants and continue efforts to integrate child care health consultation into states' Early Childhood Comprehensive Systems projects				X
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Mental health consultation is provided to 23 childcare centers. An assessment of RI child care health/mental health consultation highlighted the importance child care environments that support children's physical, cognitive, and social-emotional development, promote communication and coordination with children's medical homes, and are connected to community-based health, developmental, behavioral, and other social services and resources

The partnership with HCCNE continues. It plans region-wide training, refine existing training efforts, incorporate the Healthy Child Care America work with states' Early Childhood Comprehensive Systems projects, and explore avenues to sustain work. The Child Care Health Consultants now work with HCCNE.

c. Plan for the Coming Year

DCFHE will continue efforts to promote healthy human development across the lifespan. The Successful Start initiative will continue to implement the Successful Start Early Childhood systems plan to ensure a coordinated and effective system of early childhood services that

promotes school readiness.
The Child Care Support Network, with funding from the RI Department of Human Services, Title V, Successful Start, and the Healthy Tomorrows Partnership for Children program will expand a network of well-trained child care health and mental health consultants. Consultants will provide program-level child care health and mental health consultation for child care centers and family child care homes that is based on best practices and current research in the fields of early childhood health, behavioral health, development, and education.

Well-trained child care health and mental health consultants will continue to work collaboratively with child care providers to increase providers' knowledge, skills, and abilities in providing optimal care for young children. Consultants will assist providers in creating physical and relationship-based environments that promote children's health and wellbeing.

Specific responsibilities of health consultants will include reviewing child health records to ensure completeness (including immunization record, evidence of recent physical examination, and documentation of the child's medical home), review of the childcare program's health and safety policies and procedures (e.g. head lice, medication administration, excusing a child due to illness), modeling positive classroom techniques to support children with special needs, consultation with parents, and referrals to community services and resources, including Medicaid.

DCFHE will continue working with the HCCNE collaborative to share resources, offer training opportunities for child care health consultants, and investigate ways to measure the use of child care health consultants. The collaborative will continue work to integrate child care health consultation into states' Early Childhood Comprehensive Systems projects.

State Performance Measure 10: *Percentage of students who felt so sad or hopeless almost every day for two weeks or more in a row that they stopped doing some usual activities during the past 12 months.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective		25.7	25.5	24.2	24.2
Annual Indicator	25.7	25.7	23.6	23.6	25.0
Numerator	12896	12896	11392	11392	12900
Denominator	50241	50241	48325	48325	51599
Data Source				YRBS Survey	YRBS Survey
Is the Data Provisional or Final?				Final	Final
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	24.8	24.8	24.8	24.8	

Notes - 2009
Results for 2009 are from the YRBS conducted in 2009.

The result for this SPM has remained about the same since 2001.

Notes - 2008
Since the YRBS is conducted every other year, data for 2008 are estimated to be the same as 2007 The slight decline when comparing YRBS 2005 and YRBS 2007 is not signficant.

Notes - 2007
Data from YRBS for 2007.

a. Last Year's Accomplishments
This is the final year that Rhode Island will report on this State Performance Measure.

Identifying and meeting the emotional and behavioral health needs of children is critical for their success. Adequate capacity to address child and family mental health needs remains a statewide concern. DCFHE supported activities to promote the mental/behavioral health of the MCH population, including school age youth.

DCFHE Safe RI-Violence and Injury Prevention Program secured SAMHSA funding to support a youth suicide prevention initiative which

· Trains school personnel, clinicians, parents and staff of CBO's to recognize the signs of mental illness, depression and other risk factors for suicide and refer students to helping resources using QPR.
· Implements AFSP Interactive Screening Program at URI, PC, and Brown University.
· Includes suicide prevention in Brown University Medical School and Masters of Public Health curricula.
· Increases awareness and de-stigmatizes help seeking.

Two school-based health centers (SBHCs) continued to provide teenagers with access to comprehensive preventive health with mental health services on site or through referral

The Women's Health Screening & Referral Program (WHSRP) provided pregnancy testing and comprehensive health risk assessment and referral services to teens in Title X family planning sites. Teens identified with mental health concerns were referred to appropriate mental health assessment and/or treatment services.

DCFHE is continuing to explore the development of a RI Mental/Behavioral Health Resource Center for Schools at RI's Bradley Hospital (pedi mental health hospital) via a Certificate of Need review process. The RI Public Health Institute was funded by the RI Foundation to conduct strategic planning around the development of a mental/behavioral health resource center for schools in partnership with DCFHE. The report will be finalized and a plan of action in place this year.

The DCFHE manages thrive coordinated school health initiative in partnership with the RI Department of Education. This partnership has focused on strengthening the statewide infrastructure to address school guidance; counseling and social services; school environment; and school climate to assure safe, caring, and nurturing schools. This effort is no longer funded by the CDC, the partnership remains in tact.

A disability indicator was included in the 200 YRBS survey that permitted comparing youth with disabilities to youth without disabilities. Through the OSHCN, the RI Transition Council and RIDE's Office of Diverse Learners, the data were discussed with interested stakeholders at multiple forums. The OSHCN prepared action steps with the Transition Council to address the mental / behavioral health needs of youth with disabilities.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Continue to develop the Youth Action Research Program to provide opportunities for youth to provide input into DCFHE programs and conduct research and make recommendations for adolescent health programming				X

2. . Support new models of care to support wellness activities in schools through partnerships and innovative funding strategies.				X
3. Continue to support the Women's Health Screening & Referral Program to provide comprehensive health risk assessment to teens and refer teens in need of mental health services to appropriate resources	X			
4. Actively participate on a suicide prevention task force to mobilize support for violence and suicide prevention				X
5. Analyze 2009 Youth Risk Behavior Survey data and disseminate reports				X
6. Work with the Transition Council on self-determination and youth empowerment activities for youth with disabilities, chronic conditions and special needs.		X		
7.				
8.				
9.				
10.				

b. Current Activities
Two school-based health centers (SBHCs) continued to provide teenagers with access to comprehensive preventive health with mental health services onsite or through referral.

The Women's Health Screening & Referral Program (WHSRP) provided pregnancy testing and comprehensive health risk assessment and referral services to teens in Title X family planning sites. Teens identified with mental health concerns were referred to appropriate mental health assessment and/or treatment services.

DCFHE is continuing to explore the development of a RI Mental/Behavioral Health Resource Center for Schools at RI's Bradley Hospital via a Certificate of Need review process. The RI Public Health Institute developed a report on efforts to date and a template for a website supporting local schools in mental health issues was developed.

The DCFHE SafeRI Violence and Injury Prevention Program continues to implement the Garrett Lee Smith Memorial Youth Suicide Prevention and Early Intervention Program.

The DCFHE manages Thrive coordinated school health initiative in partnership with the RI Department of Education. This partnership has focused on strengthening the statewide infrastructure to address school guidance; counseling and social services; school environment; and school climate to assure safe, caring, and nurturing schools. This effort is no longer funded by the CDC, the partnership remains in tact

c. Plan for the Coming Year
The DFCHE will work with the RI Public Health Institute, Bradley Hospital and a large urban ring school district to a develop a cost analysis plan for a behavioral mental health resource center. DCFHE will work with the RI Association of School Principals on a toolkit for schools will be developed that is an extension of the Rhode Island Parents' Guide to Children's Mental Health.

The DCFHE will seek continued support of Youth Action Researchers to conduct action research on adolescent health issues.

DCFHE will continue to pursue models of care to support wellness activities in schools through partnerships and innovative funding strategies.

The WHSRP will continue to provide pregnancy testing and comprehensive health risk assessment and referral services to teens in Title X family planning sites. Teens identified with mental health concerns will be referred to appropriate mental health assessment and/or treatment services.

The DCFHE will develop a plan for a parent and teen resource page.

The DCFHE SafeRI Violence and Injury Prevention Program will expand implementation of the SAMHSA grant to address teen suicide prevention reaching non-core MCH planning cities that have high rates of teen suicide, East Providence and Cranston. The program will be expanded to identify young veterans and young people on active military duty and to reach young people in the RI Training School. A media campaign supporting this effort will also be implemented in participating cities.

The DCFHE will continue to work with HEALTH's CHDA to analyze 2009 Youth Risk Behavior Survey data and to produce data tools for state and local level stakeholders.

State Performance Measure 11: *Percent of families of CSHCN served by the Pediatric Practice Enhancement Project (PPEP).*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective				6	7.7
Annual Indicator	1.8	3.1	5.3	7.6	10.0
Numerator	740	1292	2200	3209	4233
Denominator	41783	41783	41783	42227	42227
Data Source				Pediatric Practice Enhancement Project	Pediatric Practice Enhancement Project
Is the Data Provisional or Final?				Final	Final
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	7.7	6.9	7.1	7.2	

Notes - 2009
The percent of families with CSHCN served by the Pediatric Practice Enhancement Project (PPEP) increased to 10% in 2009.

Since the inception of the PPEP in 2004, the number of practices and families served has grown on an annual basis. Children and youth with special healthcare needs and their families participating in the PPEP receive peer support, assistance in accessing community resources and identify barriers to an integrated system of care. An analysis of the PPEP revealed that PPEP participants utilize more healthcare at overall lower healthcare costs, since they use less institutional level care and more outpatient services.

Notes - 2008
The percent of families with CSHCN servied by the Pediatric Practice Enhancement Project (PPEP) increased to 7.6% in 2008.

Since the inception of the PPEP in 2004, the number of practices and families served has grown on an annual basis.

a. Last Year's Accomplishments
This is the final year that Rhode Island will report on this State Performance Measure.

Background:
The complex medical and social needs of children with special health care needs make it essential that they are cared for within a community system of services. Families raising children and youth with special needs struggle to navigate systems concerning health care, insurance, education, and a variety of home and community based services. Families and providers in RI have consistently reported difficulties navigating the service delivery system and accessing prescribed services.

Intervention:
The Pediatric Practice Enhancement Project strategically placed trained parent of children with special health care needs throughout the primary and specialty care service delivery system and linked families with community resources, assist physicians and families in accessing specialty services, and identify barriers to coordinated care.

Data:
Performance Measure: Percent of children with special needs (birth-18) who participate in the Pediatric Practice Enhancement Project.

2004: 236 families served through PPEP
2005: 740 families served through PPEP
2006: 1292 families served through PPEP
2007: 2200 families served through PPEP
2008: 3600 families served through PPEP

Total number of children with special health care needs (birth-18) in RI: 35,265

2006 Measure: 1292/35265 = 3.66%
2007 Measure: 2200/35265= 6.24%
2008 Measure: 3600/35265= 10.2%
2008 Target: 4.5%

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Place trained parents of children with special health care needs throughout the primary and specialty care service delivery system				X
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities
The Pediatric Practice Enhancement Project strategically places trained parent of children with special health care needs throughout the primary and specialty care service delivery system to link families with community resources, assist physicians and families in accessing specialty services, and identify barriers to coordinated care.

c. Plan for the Coming Year
HEALTH will build capacity for quality asthma education and home assessment of children with severe asthma will align reimbursement policies with evidence based asthma standards of care developed by the 2007 NHLBI National Asthma Education and Prevention Program, Guidelines for the Diagnosis and Management of Asthma. The RI Asthma Program will partner with Hasbro Children's Hospital on a pilot project that will help build capacity and provide data to support the cost-effectiveness of asthma services and sullies that will increase self-management of asthma among children with asthma and their parents, and address environmental triggers in the home. The project will have tow key components: 1) Asthma Home Assessment Training and 2) Hasbro Children's Hospital; Draw A Breath with Home Assessment. HEALTH will add all six questions from the BRFSS Child Selection Module in 20011.

E. Health Status Indicators

Introduction
There are 23 Health Status Indicators that assist the DCFHE's ability to provide information on Rhode Island residents, assist in directing public health efforts, serve as part of a surveillance and monitoring system and provide an evaluative measure of current public health efforts to support maternal and child health. This section provides an interpretation of the data, key policy and program influences on Rhode Island's ability to maintain or improve the indicator and efforts to continuously improve the health status indicator.

Health Status Indicators 01A: *The percent of live births weighing less than 2,500 grams.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	7.8	8.0	8.1	8.0	8.0
Numerator	992	992	997	958	911
Denominator	12690	12370	12371	12031	11416
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Final

Notes - 2009
Rhode Island's percent of LBW infants continues to remain at about 8%.

Notes - 2007

Data for 2007 shows an slight increase in the percent of LBW babies compared to 2006.

Narrative:
As part of a needs assessment process, the DCFHE's, in partnership with the Center for Health Data and Analysis, tracks, on an annual basis, the percent of live births weighing less than 2,500 and 1,500 grams and the percent of live singleton births weighing less than 2,500 and 1,500 grams. Data are drawn from Vital Records. This information is used to calculate low birth weight and very low birth weight. The Division looks at this data in conjunction with other maternal and child health indicators such as infant death, prematurity, and multiple births. The information is shared with community partners through the publication of our annual Title V application and a Family Health in Rhode Island summary family health plan (see Attachment 1). Data are also reported through our partnership with Rhode Island Kids Count, which publishes an annual Factbook on child wellbeing. Data are used to identify trends in subpopulations and are reported in the context of contributing factors that impact the numbers and rates. The data are monitored over time to measure the effectiveness of interventions and to determine progress towards meeting goals.

In addition, birth weight and multiple birth codes are collected at birth in the integrated electronic birth certificate/developmental risk assessment system (VR2000) and stored in KIDSNET. A report is created in KIDSNET for the RI Department of Human Service's Early Intervention Program that reports the number of infants weighing less than 1500 grams by Early Intervention participation status. This report allows the Early Intervention Program to evaluate its success at engaging this target population in services.

The WIC Program also uses low birth weight data in the preparation of the WIC state plan, including ranking the relative need of communities across the state.

Successful Start uses this data to develop recommendations for the Children's Cabinet about targeting resources to areas of highest need.

The Home Visiting program uses this data to identify children who will be offered home visits due to low birth weight.

Health Status Indicators 01B: *The percent of live singleton births weighing less than 2,500 grams.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	5.8	6.3	6.4	6.2	6.0
Numerator	704	742	759	717	656
Denominator	12175	11870	11936	11579	10951
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional

Notes - 2009
Data for 2009 continues to shows a slight decrease of LBW singleton births since 2007.

Notes - 2008

Data for 2008 shows a slight decrease of LBW singleton births compared to 2007.

Notes - 2007
Data for 2007 shows a slight increase of LBW singleton births, 6.4% compared to 6.3% for 2006.

Narrative:
As part of a needs assessment process, the DCFHE's, in partnership with the Center for Health Data and Analysis, tracks, on an annual basis, the percent of live births weighing less than 2,500 and 1,500 grams and the percent of live singleton births weighing less than 2,500 and 1,500 grams. Data are drawn from Vital Records. This information is used to calculate low birth weight and very low birth weight. The Division looks at this data in conjunction with other maternal and child health indicators such as infant death, prematurity, and multiple births. The information is shared with community partners through the publication of our annual Title V application and a Family Health in Rhode Island summary family health plan (see Attachment 1). Data are also reported through our partnership with Rhode Island Kids Count, which publishes an annual Factbook on child wellbeing. Data are used to identify trends in subpopulations and are reported in the context of contributing factors that impact the numbers and rates. The data are monitored over time to measure the effectiveness of interventions and to determine progress towards meeting goals.

In addition, birth weight and multiple birth codes are collected at birth in the integrated electronic birth certificate/developmental risk assessment system (VR2000) and stored in KIDSNET. A report is created in KIDSNET for the RI Department of Human Service's Early Intervention Program that reports the number of infants weighing less than 1500 grams by Early Intervention participation status. This report allows the Early Intervention Program to evaluate its success at engaging this target population in services.

The WIC Program also uses low birth weight data in the preparation of the WIC state plan, including ranking the relative need of communities across the state.

Successful Start uses this data to develop recommendations for the Children's Cabinet about targeting resources to areas of highest need.

The Home Visiting program uses this data to identify children who will be offered home visits due to low birth weight.

Health Status Indicators 02A: *The percent of live births weighing less than 1,500 grams.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	1.6	1.6	1.7	1.4	1.7
Numerator	198	193	216	172	195
Denominator	12690	12370	12371	12031	11416
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional

Notes - 2009

Rhode Island's percent of VLBW infants increased slightly in 2009 to 1.7% compared to 1.4% in 2007.

Notes - 2008
Data for 2008 shows a decline of VLBW infants to 1.4% compared to 1.7% in 2007.

Notes - 2007
Rhode Island's percent of VLBW infants increased slightly in 2007 to 1.7% compared to 1.6% in 2006.

Narrative:
As part of a needs assessment process, the DCFHE's, in partnership with the Center for Health Data and Analysis, tracks, on an annual basis, the percent of live births weighing less than 2,500 and 1,500 grams and the percent of live singleton births weighing less than 2,500 and 1,500 grams. Data are drawn from Vital Records. This information is used to calculate low birth weight and very low birth weight. The Division looks at this data in conjunction with other maternal and child health indicators such as infant death, prematurity, and multiple births. The information is shared with community partners through the publication of our annual Title V application and a Family Health in Rhode Island summary family health plan (see Attachment 1). Data are also reported through our partnership with Rhode Island Kids Count, which publishes an annual Factbook on child wellbeing. Data are used to identify trends in subpopulations and are reported in the context of contributing factors that impact the numbers and rates. The data are monitored over time to measure the effectiveness of interventions and to determine progress towards meeting goals.

In addition, birth weight and multiple birth codes are collected at birth in the integrated electronic birth certificate/developmental risk assessment system (VR2000) and stored in KIDSNET. A report is created in KIDSNET for the RI Department of Human Service's Early Intervention Program that reports the number of infants weighing less than 1500 grams by Early Intervention participation status. This report allows the Early Intervention Program to evaluate its success at engaging this target population in services.

The WIC Program also uses low birth weight data in the preparation of the WIC state plan, including ranking the relative need of communities across the state.

Successful Start uses this data to develop recommendations for the Children's Cabinet about targeting resources to areas of highest need.

The Home Visiting program uses this data to identify children who will be offered home visits due to low birth weights.

Health Status Indicators 02B: *The percent of live singleton births weighing less than 1,500 grams.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	2005	2006	2007	2008	2009
Annual Indicator	1.2	1.2	1.2	1.0	1.2
Numerator	145	143	149	119	133
Denominator	12175	11870	11936	11579	10951
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the					

last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional

Notes - 2009
Rhode Island's percent of singleton VLBW infants has been around 1.2% since 2005.

Notes - 2007
2007: The percent of singleton VLBW infants remains at 1.2%.

Narrative:
As part of a needs assessment process, the DCFHE's, in partnership with the Center for Health Data and Analysis, tracks, on an annual basis, the percent of live births weighing less than 2,500 and 1,500 grams and the percent of live singleton births weighing less than 2,500 and 1,500 grams. Data are drawn from Vital Records. This information is used to calculate low birth weight and very low birth weight. The Division looks at this data in conjunction with other maternal and child health indicators such as infant death, prematurity, and multiple births. The information is shared with community partners through the publication of our annual Title V application and a Family Health in Rhode Island summary family health plan (see Attachment 1). Data are also reported through our partnership with Rhode Island Kids Count, which publishes an annual Factbook on child wellbeing. Data are used to identify trends in subpopulations and are reported in the context of contributing factors that impact the numbers and rates. The data are monitored over time to measure the effectiveness of interventions and to determine progress towards meeting goals.

In addition, birth weight and multiple birth codes are collected at birth in the integrated electronic birth certificate/developmental risk assessment system (VR2000) and stored in KIDSNET. A report is created in KIDSNET for the RI Department of Human Service's Early Intervention Program that reports the number of infants weighing less than 1500 grams by Early Intervention participation status. This report allows the Early Intervention Program to evaluate its success at engaging this target population in services.

The WIC Program also uses low birth weight data in the preparation of the WIC state plan, including ranking the relative need of communities across the state.

Successful Start uses this data to develop recommendations for the Children's Cabinet about targeting resources to areas of highest need.

The Home Visiting program uses this data to identify children who will be offered home visits due to low birth weights.

Health Status Indicators 03A: *The death rate per 100,000 due to unintentional injuries among children aged 14 years and younger.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	5.0	3.5	2.9	2.7	2.7
Numerator	10	21	17	5	5
Denominator	199674	592741	586460	185916	185916
Check this box if you cannot report the					

numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional

Notes - 2009
The death rate due to unintentional injuries among children aged 0-14 remained the same at 2.7 per 100,000 for both 2008 and 2009.

Notes - 2008
The death rate due to unintentional injuries among children aged 0-14 remained about the same with 2.9 per 100,000 for 2007 and 2.7 per 100,000 for 2008

Notes - 2007
Data for 2007 reflects a 3 year average [2005-2007] and the denominator includes children aged 0-14.
Data for 2007 was 3 cases and population was 193,393.

The 3 year average shows that deaths due to unintentional injuries among children aged 0-14 declined from 3.5 per 100,000 to 2.9 per 100,000.

Narrative:
The DFCHE is responsible for injuries in school age children and young adults. DFCHE identifies the injuries that are most prevalent, populations most in need, and strategies to ameliorate risks. The DCFHE's Safe RI - -Violence and Injury Prevention Program works with the Department's Center for Health Data and Analysis to track, on an annual basis, deaths due to unintentional injuries and non-fatal injuries. Data is drawn from death records from Vital Statistics (for fatal injuries) and from Hospital Discharge Records (for non-fatal injuries). This information is shared within DFCHE and community partners through publication of our annual Title V application, local and national publications and summary family health document. Data is also reported through our partnership with Rhode Island Kids Count, which publishes an annual Factbook on child well being. Data are used to identify trends in subpopulations and are reported in the context of contributing factors that impact the numbers and rates. The data are monitored over time to measure the effectiveness of interventions and to determine progress towards meeting goals.

Health Status Indicators 03B: *The death rate per 100,000 for unintentional injuries among children aged 14 years and younger due to motor vehicle crashes.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	2.5				
Numerator	5				
Denominator	199674	193393	193393	185916	185916
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over			Yes	Yes	Yes

the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional

Notes - 2009
Data for 2009 reports 1 unintentional motor vechicle deaths.
Data reflect unintentional motor vechicle deaths to children aged 0 - 14.
Denominator from Population Estimates for 2008.

Notes - 2008
Data for 2008 reports no [0] unintentional motor vechicle deaths.
Data reflect unintentional motor vechicle deaths to children aged 0 - 14.
Denominator from Population Estimates for 2008.

Notes - 2007
Data for 2007 reports only 3 unintentional motor vechicle deaths.
Data reflect unintentional motor vechicle deaths to children aged 0 - 14.
Denominator from the US Census Estimates.

Narrative:
The DFCHE is responsible for injuries in school age children and young adults. DFCHE identifies the injuries that are most prevalent, populations most in need, and strategies to ameliorate risks. The DCFHE's Safe RI - -Violence and Injury Prevention Program works with the Department's Center for Health Data and Analysis to track, on an annual basis, deaths due to unintentional injuries and non-fatal injuries. Data is drawn from death records from Vital Statistics (for fatal injuries) and from Hospital Discharge Records (for non-fatal injuries). This information is shared within DFCHE and community partners through publication of our annual Title V application, local and national publications and summary family health document. Data is also reported through our partnership with Rhode Island Kids Count, which publishes an annual Factbook on child well being. Data are used to identify trends in subpopulations and are reported in the context of contributing factors that impact the numbers and rates. The data are monitored over time to measure the effectiveness of interventions and to determine progress towards meeting goals.

Health Status Indicators 03C: *The death rate per 100,000 from unintentional injuries due to motor vehicle crashes among youth aged 15 through 24 years.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	13.9	14.4	12.5	11.5	11.5
Numerator	22	23	20	18	18
Denominator	158534	160131	160131	157126	157126
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional

Notes - 2009

Data reflects the same rate of unintentional deaths involving a motor vechile at 11.5 per 100,000 for both 2008 and 2009.
Denominator from the Population Estimates - 2008.

Notes - 2008
Data for 2008 reflects a slight decline in the rate of unintentional deaths involving a motor vechile at 11.5 per 100,000 for 2008 compared to 12.5 for 2007.
Denominator from the Population Estimates - 2008.

Notes - 2007
Data for 2007 reflects an decline in unintentional deaths involving a motor vechile for those aged 15 - 24. The rate per 100,000 is 12.5 in 2007 compared to 14.4 for 2006.

Denominator from the US Census Estimate.

Narrative:
The DFCHE is responsible for injuries in school age children and young adults. DFCHE identifies the injuries that are most prevalent, populations most in need, and strategies to ameliorate risks. The DCFHE's Safe RI - -Violence and Injury Prevention Program works with the Department's Center for Health Data and Analysis to track, on an annual basis, deaths due to unintentional injuries and non-fatal injuries. Data is drawn from death records from Vital Statistics (for fatal injuries) and from Hospital Discharge Records (for non-fatal injuries). This information is shared within DFCHE and community partners through publication of our annual Title V application, local and national publications and summary family health document. Data is also reported through our partnership with Rhode Island Kids Count, which publishes an annual Factbook on child well being. Data are used to identify trends in subpopulations and are reported in the context of contributing factors that impact the numbers and rates. The data are monitored over time to measure the effectiveness of interventions and to determine progress towards meeting goals.

Health Status Indicators 04A: *The rate per 100,000 of all nonfatal injuries among children aged 14 years and younger.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	138.7	117.4	131.9	146.3	146.3
Numerator	277	227	255	272	272
Denominator	199674	193393	193393	185916	185916
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional

Notes - 2009
The provisional rate of all nonfatal injuries remained the same in 2009 at 146.3 per 100,000 .

Denominator reflects children aged 0 -14 and denominator from Population Estimates: 2008.

Notes - 2008
The rate of all nonfatal injuries increased from 131.9 per 100,000 in 2007 to 146.3 in 2008.

Denominator reflects children aged 0 -14 and denominator from Population Estimates: 2008.

Notes - 2007
Data reflect children aged 0 -14 and denominator from US Census Estimate.

The rate of all nonfatal injuries increased from 117.4 per 100,000 in 2006 to 131.9 in 2007.

Narrative:
The DFCHE is responsible for injuries in school age children and young adults. DFCHE identifies the injuries that are most prevalent, populations most in need, and strategies to ameliorate risks. The DCFHE's Safe RI - -Violence and Injury Prevention Program works with the Department's Center for Health Data and Analysis to track, on an annual basis, deaths due to unintentional injuries and non-fatal injuries. Data is drawn from death records from Vital Statistics (for fatal injuries) and from Hospital Discharge Records (for non-fatal injuries). This information is shared within DFCHE and community partners through publication of our annual Title V application, local and national publications and summary family health document. Data is also reported through our partnership with Rhode Island Kids Count, which publishes an annual Factbook on child well being. Data are used to identify trends in subpopulations and are reported in the context of contributing factors that impact the numbers and rates. The data are monitored over time to measure the effectiveness of interventions and to determine progress towards meeting goals.

Health Status Indicators 04B: *The rate per 100,000 of nonfatal injuries due to motor vehicle crashes among children aged 14 years and younger.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	19.5	7.8	8.3	8.6	7.5
Numerator	39	15	16	16	14
Denominator	199674	193393	193393	185916	185916
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional

Notes - 2009
The rate of nonfatal injuries due to motor vehicle crashes declined to 7.5 per 100,000 for 2009 compared to 8.6 per 100,000 for 2008.

Denominator for Population Estimates for 2008 and reflect children aged 0 -14.

Notes - 2008
The rate of nonfatal injuries due to motor vehicle crashes increased slightly to 8.6 for 2008.

Denominator for Population Estimates for 2008 and reflect children aged 0 -14.

Notes - 2007
Data reflect children aged 0 -14 and denominator from US Census Estimate.

The rate of nonfatal injuries due to motor vehicle crashes increased from 7.8 per 100,000 in 2006 to 8.3 in 2007.

Narrative:
The DFCHE is responsible for injuries in school age children and young adults. DFCHE identifies the injuries that are most prevalent, populations most in need, and strategies to ameliorate risks. The DCFHE's Safe RI - -Violence and Injury Prevention Program works with the Department's Center for Health Data and Analysis to track, on an annual basis, deaths due to unintentional injuries and non-fatal injuries. Data is drawn from death records from Vital Statistics (for fatal injuries) and from Hospital Discharge Records (for non-fatal injuries). This information is shared within DFCHE and community partners through publication of our annual Title V application, local and national publications and summary family health document. Data is also reported through our partnership with Rhode Island Kids Count, which publishes an annual Factbook on child well being. Data are used to identify trends in subpopulations and are reported in the context of contributing factors that impact the numbers and rates. The data are monitored over time to measure the effectiveness of interventions and to determine progress towards meeting goals.

Health Status Indicators 04C: *The rate per 100,000 of nonfatal injuries due to motor vehicle crashes among youth aged 15 through 24 years.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	53.6	75.6	61.8	56.6	61.7
Numerator	85	121	99	89	97
Denominator	158534	160131	160131	157126	157126
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional

Notes - 2009
The rate of nonfatal injuries due to motor vehicle crashes increased from 56.6 per 100,000 in 2008 to 61.7 per 100,000 in 2009.
Data reflect youth aged 15-24 and denominator from Population Estimates - 2008.

Notes - 2008
The rate of nonfatal injuries due to motor vehicle crashes decreased from 61.8 per 100,000 in 2007 to 56.6 per 100,000 in 2008.
Data reflect youth aged 15-24 and denominator from Population Estimates - 2008.

Notes - 2007
Data reflect youth aged 15-24 and denominator from US Census Estimate.

The rate of nonfatal injuries due to motor vehicle crashes decreased from 75.6 per 100,000 in 2006 to 61.8 in 2007.

Narrative:
The DFCHE is responsible for injuries in school age children and young adults. DFCHE identifies the injuries that are most prevalent, populations most in need, and strategies to ameliorate risks. The DCFHE's Safe RI - -Violence and Injury Prevention Program works with the Department's Center for Health Data and Analysis to track, on an annual basis, deaths due to unintentional injuries and non-fatal injuries. Data is drawn from death records from Vital Statistics (for fatal injuries) and from Hospital Discharge Records (for non-fatal injuries). This information is shared within DFCHE and community partners through publication of our annual Title V application, local and national publications and summary family health document. Data is also reported through our partnership with Rhode Island Kids Count, which publishes an annual Factbook on child well being. Data are used to identify trends in subpopulations and are reported in the context of contributing factors that impact the numbers and rates. The data are monitored over time to measure the effectiveness of interventions and to determine progress towards meeting goals.

Health Status Indicators 05A: *The rate per 1,000 women aged 15 through 19 years with a reported case of chlamydia.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	23.2	20.0	20.5	22.3	24.4
Numerator	873	809	829	881	962
Denominator	37676	40481	40481	39428	39428
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2009
Although there was a small increase in the annual indicator from 2006 through 2009, this measure has been relatively stable over the four year period from 2006 through 2009.

Denominator from the Population Estimates.

Notes - 2008
Although there was a small decrease in the annual indicator from 2006 through 2008 when compared to 2004 to 2005, this measure has been relatively stable over the five year period from 2004 through 2008.

Denominator from the US Census Estimates.

Notes - 2007
Although there was a small decrease in the annual indicator from 2006 through 2008 when compared to 2004 to 2005, this measure has been relatively stable over the five year period from 2004 through 2008.

Denominator from the US Census Estimates

Narrative:
The DFCHE is responsible for the health of school age children, adolescent health, the state's school-based health center initiative, and administration of the state's Title X family planning program. Data on reported cases of chlamydia, an often silent and dangerous sexually transmitted disease, is critical to identify needs of subpopulations and to develop effective planning and prevention interventions. The RI Department of Health Laboratory and its Sexually Transmitted Disease program track cases and report to the DFCHE data by demographic factors (e.g. age, race, ethnicity, city/town residence, community health centers, etc.) for needs assessment purposes. The DFCHE Title X family planning program partners with the STD Program and the State Laboratory tracks Chlamydia tests, provided through the Department's Infertility Project. Information is shared with community partners through the publication of our annual Title V application, MCH data briefs, Title V Needs Assessment Summary and materials produced by the STD program. Data are used to identify trends in subpopulations and are reported in the context of contributing factors that impact the numbers and rates. The data are monitored over time to measure the effectiveness of interventions and to determine progress towards meeting goals.

Health Status Indicators 05B: *The rate per 1,000 women aged 20 through 44 years with a reported case of chlamydia.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	7.9	7.1	7.5	8.2	8.9
Numerator	1459	1319	1394	1468	1590
Denominator	183863	186155	186155	178493	178493
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2009
The rate of Chlamydia for women aged 20 -44 increased from 7.1 per 1,000 in 2006 to 8.9 per 1,000 in 2009.

Denominator from the PopulationEstimates.

Notes - 2008
Denominator from the US Census Estimates.

Notes - 2007
Denominator from the US Census Estimates.

Narrative:
The DFCHE is responsible for the health of school age children, adolescent health, the state's school-based health center initiative, and administration of the state's Title X family planning program. Data on reported cases of chlamydia, an often silent and dangerous sexually transmitted disease, is critical to identify needs of subpopulations and to develop effective planning and prevention interventions. The RI Department of Health Laboratory and its Sexually

Transmitted Disease program track cases and report to the DFCHE data by demographic factors (e.g. age, race, ethnicity, city/town residence, community health centers, etc.) for needs assessment purposes. The DFCHE Title X family planning program partners with the STD Program and the State Laboratory tracks Chlamydia tests, provided through the Department's Infertility Project. Information is shared with community partners through the publication of our annual Title V application, MCH data briefs, Title V Needs Assessment Summary and materials produced by the STD program. Data are used to identify trends in subpopulations and are reported in the context of contributing factors that impact the numbers and rates. The data are monitored over time to measure the effectiveness of interventions and to determine progress towards meeting goals.

Health Status Indicators 06A: *Infants and children aged 0 through 24 years enumerated by sub-populations of age group and race. (Demographics)*

HSI #06A - Demographics (TOTAL POPULATION)

CATEGORY TOTAL POPULATION BY RACE	**Total All Races**	**White**	**Black or African American**	**American Indian or Native Alaskan**	**Asian**	**Native Hawaiian or Other Pacific Islander**	**More than one race reported**	**Other and Unknown**
Infants 0 to 1	12127	9726	1185	147	450	25	594	0
Children 1 through 4	48612	39177	4643	693	1712	75	2312	0
Children 5 through 9	61144	50572	5300	695	2155	106	2316	0
Children 10 through 14	65004	55088	5440	541	1981	112	1842	0
Children 15 through 19	79740	67558	6730	735	2700	150	1867	0
Children 20 through 24	74285	63285	6024	563	2705	152	1556	0
Children 0 through 24	340912	285406	29322	3374	11703	620	10487	0

Notes - 2011

Narrative:
As part of a needs assessment process, the DFCHE, in partnership with the Center for Health Data and Analysis tracks, on an annual basis, subpopulation trends in age group, race, and ethnicity in order to conduct cross-tabulations of factors that impact health and target prevention activities in populations most in need. For example, teen birth rates are highest among Hispanic populations, which also have high rates of poverty. Teen pregnancy prevention efforts, therefore, are focused on the Hispanic community. Data are drawn from Vital Records, Department of Administration Statewide Planning, U.S. Bureau of the Census, and other population estimate sources. This information is used to calculate rates of various maternal and child health indicators. The information is shared with community partners through the publication of our annual Title V application and a Family Health in Rhode Island summary family health plan. Data are also reported through our partnership with Rhode Island Kids Count, which publishes an annual Factbook on child wellbeing. Data are used to identify trends in subpopulations and are reported in the context of contributing factors that impact the numbers and rates. The data is monitored over time to measure the effectiveness of interventions and to determine progress towards meeting goals.

In addition, date of birth, race, and ethnicity are collected at birth in the integrated electronic birth

certificate/developmental risk assessment system (VR2000) and stored in KIDSNET. Age, and when possible, race and ethnicity are also collected in KIDSNET when new records are opened for children not born in Rhode Island. Using KIDSNET data, Newborn Screening programs (metabolic and hearing) report information on screening and follow-up rates and outcomes by race, ethnicity, and age to federal partners. Newborn Screening programs also use PRAMS data broken down by race/ethnicity to identify subpopulations that should be targeted for newborn screening awareness. This data will be monitored in the future to determine the effectiveness of parental informing strategies.

The WIC Program uses this data in the preparation of the WIC state plan, including ranking the relative need of communities. In addition, WIC uses this data to determine the effectiveness of outreach activities.

The Office of Immunization uses this data to assist in monitoring vaccination coverage rates among children and adolescents, identify disparities and disseminate information to key stakeholders.

Programs that promote healthy childcare use this data to target service delivery in areas of high need and appropriately direct services that are specifically designed to meet the needs of various cultural groups

Health Status Indicators 06B: *Infants and children aged 0 through 24 years enumerated by sub-populations of age group and Hispanic ethnicity. (Demographics)*

HSI #06B - Demographics (TOTAL POPULATION)

CATEGORY TOTAL POPULATION BY HISPANIC ETHNICITY	**Total NOT Hispanic or Latino**	**Total Hispanic or Latino**	**Ethnicity Not Reported**
Infants 0 to 1	9220	2907	0
Children 1 through 4	37848	10764	0
Children 5 through 9	49102	12042	0
Children 10 through 14	53466	11538	0
Children 15 through 19	67567	12173	0
Children 20 through 24	63795	10490	0
Children 0 through 24	280998	59914	0

Notes - 2011

Narrative:
As part of a needs assessment process, the DFCHE, in partnership with the Center for Health Data and Analysis tracks, on an annual basis, subpopulation trends in age group, race, and ethnicity in order to conduct cross-tabulations of factors that impact health and target prevention activities in populations most in need. For example, teen birth rates are highest among Hispanic populations, which also have high rates of poverty. Teen pregnancy prevention efforts, therefore, are focused on the Hispanic community. Data are drawn from Vital Records, Department of Administration Statewide Planning, U.S. Bureau of the Census, and other population estimate sources. This information is used to calculate rates of various maternal and child health indicators. The information is shared with community partners through the publication of our annual Title V application and a Family Health in Rhode Island summary family health plan. Data are also reported through our partnership with Rhode Island Kids Count, which publishes an annual Factbook on child wellbeing. Data are used to identify trends in subpopulations and are reported in the context of contributing factors that impact the numbers and rates. The data is

monitored over time to measure the effectiveness of interventions and to determine progress towards meeting goals.

In addition, date of birth, race, and ethnicity are collected at birth in the integrated electronic birth certificate/developmental risk assessment system (VR2000) and stored in KIDSNET. Age, and when possible, race and ethnicity are also collected in KIDSNET when new records are opened for children not born in Rhode Island. Using KIDSNET data, Newborn Screening programs (metabolic and hearing) report information on screening and follow-up rates and outcomes by race, ethnicity, and age to federal partners. Newborn Screening programs also use PRAMS data broken down by race/ethnicity to identify subpopulations that should be targeted for newborn screening awareness. This data will be monitored in the future to determine the effectiveness of parental informing strategies.

The WIC Program uses this data in the preparation of the WIC state plan, including ranking the relative need of communities. In addition, WIC uses this data to determine the effectiveness of outreach activities.

The Office of Immunization uses this data to assist in monitoring vaccination coverage rates among children and adolescents, identify disparities and disseminate information to key stakeholders.

Programs that promote healthy childcare use this data to target service delivery in areas of high need and appropriately direct services that are specifically designed to meet the needs of various cultural groups

Health Status Indicators 07A: *Live births to women (of all ages) enumerated by maternal age and race. (Demographics)*

HSI #07A - Demographics (Total live births)

CATEGORY Total live births	**Total All Races**	**White**	**Black or African American**	**American Indian or Native Alaskan**	**Asian**	**Native Hawaiian or Other Pacific Islander**	**More than one race reported**	**Other and Unknown**
Women < 15	9	1	0	0	0	0	1	7
Women 15 through 17	366	127	31	5	15	0	29	159
Women 18 through 19	685	322	60	8	17	0	45	233
Women 20 through 34	8399	5300	576	45	422	1	313	1742
Women 35 or older	1957	1440	109	3	90	0	63	252
Women of all ages	11416	7190	776	61	544	1	451	2393

Notes - 2011

Narrative:
As part of a needs assessment process, the DFCHE in partnership with the Center for Health Data and Analysis, tracks, on an annual basis, live births to women (of all ages) enumerated by maternal age, race, and ethnicity. These data are used to calculate fertility rates among women of all ages. They are also used to calculate overall pregnancy rates and teen pregnancy rates. Data

are drawn from Vital Records. This information is shared with community partners through the publication of our annual Title V application and a Family Health in Rhode Island summary family health plan. Data are also reported through our partnership with Rhode Island Kids Count, which publishes an annual Factbook on child wellbeing. Data are used to identify trends in subpopulations and are reported in the context of contributing factors that impact the numbers and rates. The data are monitored over time to measure the effectiveness of interventions and to determine progress towards meeting goals.

All live births, maternal date of birth, race, and ethnicity are collected in the integrated electronic birth certificate/developmental risk screening system (VR2000) and stored in KIDSNET.

The WIC Program uses birth data in the preparation of the WIC state plan, including ranking the relative need of communities across the state.

Health Status Indicators 07B: *Live births to women (of all ages) enumerated by maternal age and Hispanic ethnicity. (Demographics)*

HSI #07B - Demographics (Total live births)

CATEGORY Total live births	**Total NOT Hispanic or Latino**	**Total Hispanic or Latino**	**Ethnicity Not Reported**
Women < 15	1	6	2
Women 15 through 17	177	173	16
Women 18 through 19	404	257	24
Women 20 through 34	6302	1818	279
Women 35 or older	1611	246	100
Women of all ages	8495	2500	421

Notes - 2011

Narrative:
As part of a needs assessment process, the DFCHE in partnership with the Center for Health Data and Analysis, tracks, on an annual basis, live births to women (of all ages) enumerated by maternal age, race, and ethnicity. These data are used to calculate fertility rates among women of all ages. They are also used to calculate overall pregnancy rates and teen pregnancy rates. Data are drawn from Vital Records. This information is shared with community partners through the publication of our annual Title V application and a Family Health in Rhode Island summary family health plan. Data are also reported through our partnership with Rhode Island Kids Count, which publishes an annual Factbook on child wellbeing. Data are used to identify trends in subpopulations and are reported in the context of contributing factors that impact the numbers and rates. The data are monitored over time to measure the effectiveness of interventions and to determine progress towards meeting goals.

All live births, maternal date of birth, race, and ethnicity are collected in the integrated electronic birth certificate/developmental risk screening system (VR2000) and stored in KIDSNET.

The WIC Program uses birth data in the preparation of the WIC state plan, including ranking the relative need of communities across the state.

Health Status Indicators 08A: *Deaths of infants and children aged 0 through 24 years enumerated by age subgroup and race. (Demographics)*

HSI #08A - Demographics (Total deaths)

CATEGORY Total deaths	**Total All Races**	**White**	**Black or African American**	**American Indian or Native Alaskan**	**Asian**	**Native Hawaiian or Other Pacific Islander**	**More than one race reported**	**Other and Unknown**
Infants 0 to 1	67	40	12	0	5	0	0	10
Children 1 through 4	5	5	0	0	0	0	0	0
Children 5 through 9	8	5	1	0	2	0	0	0
Children 10 through 14	10	8	2	0	0	0	0	0
Children 15 through 19	28	19	1	0	0	0	0	8
Children 20 through 24	47	36	3	0	1	0	0	7
Children 0 through 24	165	113	19	0	8	0	0	25

Notes - 2011

Narrative:
As part of a needs assessment process, the DCFHE's in partnership with the Center for Health Data and Analysis, tracks, on an annual basis, deaths to infants and children aged 0 through 24 years enumerated by age subgroup, race, and ethnicity in order to conduct cross-tabulations of factors that impact health and target prevention activities to populations most in need. The DCFHE tracks data by cause of death, age, and geographical areas and looks at insurance status and other variables. Data are drawn from Vital Records. The DCFHE and the Center for Health Data and Analysis works with programs to identify causes of death and to identify effective prevention strategies. The Center for Health and Data and analysis and the SafeRI- Violence and Injury Prevention Program participates on a child death review team focused on preventable deaths among all children and adolescents. Information is shared with community partners through the publication of our annual Title V application and a Family Health in Rhode Island summary family health plan. Data are also reported through our partnership with Rhode Island Kids Count, which publishes an annual Factbook on child wellbeing. Data are used to identify trends in subpopulations and are reported in the context of contributing factors that impact the numbers and rates. The data are monitored over time to measure the effectiveness of interventions and to determine progress towards meeting goals.

Deaths to infants that occur prior to discharge from a maternity hospital are collected in the integrated electronic birth certificate/developmental risk assessment system (VR2000) along with date of birth and race/ethnicity data and stored in KIDSNET. KIDSNET also works with Vital Records and other processes to record infant and child death in KIDSNET.

Health Status Indicators 08B: *Deaths of infants and children aged 0 through 24 years enumerated by age subgroup and Hispanic ethnicity. (Demographics)*

HSI #08B - Demographics (Total deaths)

CATEGORY Total deaths	**Total NOT Hispanic or Latino**	**Total Hispanic or Latino**	**Ethnicity Not Reported**
Infants 0 to 1	54	9	4
Children 1 through 4	5	0	0
Children 5 through 9	4	4	0
Children 10 through 14	9	1	0
Children 15 through 19	19	9	0
Children 20 through 24	40	7	0
Children 0 through 24	131	30	4

Notes - 2011

Narrative:
As part of a needs assessment process, the DCFHE's in partnership with the Center for Health Data and Analysis, tracks, on an annual basis, deaths to infants and children aged 0 through 24 years enumerated by age subgroup, race, and ethnicity in order to conduct cross-tabulations of factors that impact health and target prevention activities to populations most in need. The DCFHE tracks data by cause of death, age, and geographical areas and looks at insurance status and other variables. Data are drawn from Vital Records. The DCFHE and the Center for Health Data and Analysis works with programs to identify causes of death and to identify effective prevention strategies. The Center for Health and Data and Analysis and the SafeRI- Violence and Injury Prevention Program participates on a child death review team focused on preventable deaths among all children and adolescents. Information is shared with community partners through the publication of our annual Title V application and a Family Health in Rhode Island summary family health plan. Data are also reported through our partnership with Rhode Island Kids Count, which publishes an annual Factbook on child wellbeing. Data are used to identify trends in subpopulations and are reported in the context of contributing factors that impact the numbers and rates. The data are monitored over time to measure the effectiveness of interventions and to determine progress towards meeting goals.

Deaths to infants that occur prior to discharge from a maternity hospital are collected in the integrated electronic birth certificate/developmental risk assessment system (VR2000) along with date of birth and race/ethnicity data and stored in KIDSNET. KIDSNET also works with Vital Records and other processes to record infant and child death in KIDSNET.

Health Status Indicators 09A: *Infants and children aged 0 through 19 years in miscellaneous situations or enrolled in various State programs enumerated by race. (Demographics)*

HSI #09A - Demographics (Miscellaneous Data)

CATEGORY Misc Data BY RACE	**Total All Races**	**White**	**Black or African American**	**American Indian or Native Alaskan**	**Asian**	**Native Hawaiian or Other Pacific Islander**	**More than one race reported**	**Other and Unknown**	**Specific Reporting Year**
All children 0 through 19	266627	222121	23298	2811	8998	468	8931	0	2008
Percent in household headed by single parent	34.0	24.0	35.0	48.0	32.0	0.0	0.0	0.0	2008

Percent in TANF (Grant) families	5.4	27.8	12.5	0.3	1.4	0.0	0.0	58.0	2009
Number enrolled in Medicaid	89746	34522	11667	359	1346	0	0	41852	2009
Number enrolled in SCHIP	13015	4309	718	49	215	0	0	7724	2009
Number living in foster home care	1910	1215	348	19	40	0	176	112	2009
Number enrolled in food stamp program	53220	19820	7284	189	754	0	0	25173	2009
Number enrolled in WIC	23173	15801	3834	131	704	472	2231	0	2009
Rate (per 100,000) of juvenile crime arrests	4307.0	2946.0	13977.0	0.0	3103.0	0.0	0.0	8545.0	2009
Percentage of high school drop-outs (grade 9 through 12)	14.0	11.0	18.0	12.0	17.0	0.0	0.0	0.0	2009

Notes - 2011
Data from US Census, Resident Population Estimates: 2008

Data source: 2010 Rhode Island Kids Count Factbook & DHS.
Reflects families with children aged 0 thru 17.

Data source: 2010 Rhode Island Kids Count Factbook.
Table: 'RI Works' and reflects families with children aged 0 thru 18.
Race and Hispanic orgin are estimates only.

Data source: 2010 Rhode Island Kids Count Factbook & DHS.
Table: 'Children's Health Insurance' for children under the age of 19.
Race and Hispanic orgin are estimates only.

Data source: Department of Human Services
CHIP for children aged 0-8.
Race and Hispanic orgin are estimates only.

Data source: 2010 Rhode Island Kids Count Factbook & DHS.
Table: 'Children Receiving SNAP Benefits' for children under the age of 18.
Race and Hispanic orgin are estimates only.

Data source: Women, Infants and Children [WIC Program].
For children and women aged 0 thru 19.

Data source: 2010 Rhode Island Kids Count Factbook.
Table: 'Juveniles Referred to Family Court'.
Race and Hispanic orgin are estimates only and 2000 Census was used for the denominator.

Data source: 2010 Rhode Island Kids Count Factbook.
Table: 'High School Graduation Rate.'
Race and Hispanic orgin are estimates only.

Data source: Department for Children, Youth and Families
For children aged 0-19.

Narrative:
As part of a needs assessment process, the DCFHE tracks subpopulation trends in age group, race, and ethnicity in order to conduct cross-tabulations of factors that impact health and target prevention activities in populations most in need. The DCFHE in partnership with the Center for Health Data and Analysis tracks, on an annual basis, infants and children aged 0 through 19 years in miscellaneous situations or enrolled in various state programs enumerated by race and ethnicity. Data is drawn from program reports, the U.S. Bureau of the Census, and Vital Records. . Data are used to identify trends in subpopulations and are reported in the context of contributing factors that impact the numbers and rates. The data are monitored over time to measure the effectiveness of interventions and to determine progress towards meeting goals.

Race/ethnicity data are collected at birth in the integrated electronic birth certificate/developmental risk assessment system (VR2000) and stored in KIDSNET. When possible, race and ethnicity are also collected in KIDSNET when new records are opened for children not born in Rhode Island. KIDSNET includes program-level data for children born on or after January 1, 1997 for the following programs: Early Intervention, Family Outreach (home visiting), Immunization, Lead Poisoning Prevention, and Newborn Screening (metabolic, hearing, and developmental risk). KIDSNET generates program data enumerated by race and ethnicity for program use.

The WIC Program also uses data captured in HSI #09A and 09B in the preparation of the WIC state plan, including ranking the relative need of communities. The program also uses this data to assess the effectiveness of WIC outreach activities.

The Immunization Program uses these data to: support federally funded Vaccine for Children (VFC) activities, identify immunization need and disparities, identify unique educational needs of target populations, determine translation needs/requirements for educational materials, outreach to key external partners, and evaluate program success by comparing data to the number of eligible children.

Successful Start and RI LAUNCH uses this data to develop recommendations for early childhood systems and services about targeting resources to areas of highest need. The data will help policy makers help determine existing services, the degree to which they meet population needs and what additional services are needed to provide comprehensive prevention efforts.

The Adolescent Health Program uses this data to develop recommendations for adolescent systems and services, targeting resources to highest needs. The data will help policy makers determine existing services, the degree to which they meet population needs and what additional services are needed to provide comprehensive prevention efforts.

Health Status Indicators 09B: *Infants and children aged 0 through 19 years in miscellaneous situations or enrolled in various State programs enumerated by Hispanic ethnicity. (Demographics)*

HSI #09B - Demographics (Miscellaneous Data)

CATEGORY	Total NOT	Total	Ethnicity Not	Specific

Miscellaneous Data BY HISPANIC ETHNICITY	**Hispanic or Latino**	**Hispanic or Latino**	**Reported**	**Reporting Year**
All children 0 through 19	217203	49424	0	2008
Percent in household headed by single parent	25.0	50.0	25.0	2008
Percent in TANF (Grant) families	25.4	16.6	58.0	2009
Number enrolled in Medicaid	32308	15616	41822	2009
Number enrolled in SCHIP	0	2633	10382	2009
Number living in foster home care	1358	474	78	2009
Number enrolled in food stamp program	16426	11621	25173	2009
Number enrolled in WIC	15214	10190	0	2009
Rate (per 100,000) of juvenile crime arrests	4041.0	4184.0	5572.0	2009
Percentage of high school drop-outs (grade 9 through 12)	19.0	23.0	0.0	2009

Notes - 2011
Data from US Census, Resident Population Estimates: 2008
Ethnicity break down by programs are estimated.

Narrative:
As part of a needs assessment process, the DCFHE tracks subpopulation trends in age group, race, and ethnicity in order to conduct cross-tabulations of factors that impact health and target prevention activities in populations most in need. The DCFHE in partnership with the Center for Health Data and Analysis tracks, on an annual basis, infants and children aged 0 through 19 years in miscellaneous situations or enrolled in various state programs enumerated by race and ethnicity. Data is drawn from program reports, the U.S. Bureau of the Census, and Vital Records. . Data are used to identify trends in subpopulations and are reported in the context of contributing factors that impact the numbers and rates. The data are monitored over time to measure the effectiveness of interventions and to determine progress towards meeting goals.

Race/ethnicity data are collected at birth in the integrated electronic birth certificate/developmental risk assessment system (VR2000) and stored in KIDSNET. When possible, race and ethnicity are also collected in KIDSNET when new records are opened for children not born in Rhode Island. KIDSNET includes program-level data for children born on or after January 1, 1997 for the following programs: Early Intervention, Family Outreach (home visiting), Immunization, Lead Poisoning Prevention, and Newborn Screening (metabolic, hearing, and developmental risk). KIDSNET generates program data enumerated by race and ethnicity for program use.

The WIC Program also uses data captured in HSI #09A and 09B in the preparation of the WIC state plan, including ranking the relative need of communities. The program also uses this data to assess the effectiveness of WIC outreach activities.

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Health Status Indicators 10: *Geographic living area for all children aged 0 through 19 years.*

HSI #10 - Demographics (Geographic Living Area)

Geographic Living Area	Total
Living in metropolitan areas	251642
Living in urban areas	266372
Living in rural areas	0
Living in frontier areas	0
Total - all children 0 through 19	266372

Notes - 2011
HSI #10 data are estimated.

Narrative:
As part of a needs assessment process, the DCFHE in partnership with the Center for Health Data and Analysis tracks, on an annual basis, the geographic living area for all resident children aged 0 through 19 years in order to conduct cross-tabulations by geographic area to target prevention activities. For example, teen birth rates are highest in the core MCH planning cities, which have high rates of minority populations, poverty, and school failure. Teen pregnancy prevention efforts, therefore, are focused on those communities. Data is drawn from Vital Statistics Records and U.S. Bureau of the Census data. The RI Department of Health has implemented a geographical information system for use by all staff. Databases are gradually being geo-coded for mapping purposes. Information is shared with community partners through program reports and the publication of our annual Title V application and a Family Health in Rhode Island summary family health plan. Data are also reported through our partnership with Rhode Island Kids Count, which publishes an annual Factbook on child wellbeing. Data are used to identify trends in subpopulations and are reported in the context of contributing factors that impact the numbers and rates. The data are monitored over time to measure the effectiveness of interventions and to determine progress towards meeting goals.

Address at the time of birth is collected at birth in the integrated electronic birth certificate/developmental risk assessment system (VR2000) and stored in KIDSNET. When possible, address information is also collected in KIDSNET when new records are opened on children not born in Rhode Island. Address information is updated by KIDSNET users such as home visitors, the lead program, primary care providers, and others aware of address changes. KIDSNET data can be analyzed at the zip code, region, or city/town level. This data can then be shared with home visiting agencies and local coalitions working to address public health issues within communities. Geographic data has also been used to inform policymakers and planners working on disaster plans such as pandemic flu. KIDSNET, in collaboration with the Center for Health Data and analysis Geographic Information System (GIS) Program, now has the capacity to report data by any geographic level allowing for refined geographic analysis and production of maps.

The WIC Program uses geographic data on children in preparation of the WIC state plan, including ranking the relative need of communities. The program also uses this data to assess the effectiveness of outreach activities.

The First Connections Home Visiting Program uses this data for program planning to ensure that resources are targeted to areas of high need and density.

The Immunization Program uses this data to assist in monitoring vaccination coverage rates in cities and towns, identify immunization need and disparities, and identify unique educational/outreach needs of targeted populations.

Health Status Indicators 11: *Percent of the State population at various levels of the federal poverty level.*

HSI #11 - Demographics (Poverty Levels)

Poverty Levels	Total
Total Population	1045968.0
Percent Below: 50% of poverty	4.5
100% of poverty	10.9
200% of poverty	26.6

Notes - 2011

Narrative:
As part of a needs assessment process, the DCFHE in partnership with the Center for Health Data and Analysis tracks, on an annual basis, the percent of the population (state and child) at various levels of the federal poverty level in order to conduct cross-tabulations by poverty to target prevention activities in areas most in need. Poverty is a risk factor for nearly every poor health outcome and therefore must be addressed as part of strategic planning to improve health and wellbeing of maternal and child populations. For example, poverty is a risk factor for teen pregnancy and school failure. Teen pregnancy prevention efforts, therefore, must incorporate strategies to give youth hope for the future and skills to meet the demands of a 21st century workforce. Data is drawn from the U.S. Bureau of the Census and other survey and program data. This information is shared with community partners through program reports and the publication of our annual Title V application and a Family Health in Rhode Island summary family health plan. Data are also reported through our partnership with Rhode Island Kids Count, which publishes an annual Factbook on child wellbeing. Data are used to identify trends in subpopulations and are reported in the context of contributing factors that impact the numbers and rates. The data are monitored over time to measure the effectiveness of interventions and to determine progress towards meeting goals.

In addition, the WIC Program uses poverty-level data in preparation of the WIC state plan, including ranking the relative need of communities. The program also uses this data to assess the effectiveness of outreach activities.

Early childhood programs use this data to determine estimated need for capacity of programs that serve families with demographic risk factors and to determine areas of targeted outreach.

Both programs designed to make out of home child care environments healthier and safer and programs targeted toward providing home visits to families with newborns use this data to focus efforts on areas of highest need.

The Adolescent Health Program uses this data to develop recommendations for adolescent systems and services, targeting resources to highest needs. The data will help policy makers determine existing services, the degree to which they meet population needs and what additional

services are needed to provide comprehensive prevention efforts.

Health Status Indicators 12: *Percent of the State population aged 0 through 19 years at various levels of the federal poverty level.*

HSI #12 - Demographics (Poverty Levels)

Poverty Levels	Total
Children 0 through 19 years old	266372.0
Percent Below: 50% of poverty	7.4
100% of poverty	16.7
200% of poverty	35.2

Notes - 2011

Narrative:
As part of a needs assessment process, the DCFHE in partnership with the Center for Health Data and Analysis tracks, on an annual basis, the percent of the population (state and child) at various levels of the federal poverty level in order to conduct cross-tabulations by poverty to target prevention activities in areas most in need. Poverty is a risk factor for nearly every poor health outcome and therefore must be addressed as part of strategic planning to improve health and wellbeing of maternal and child populations. For example, poverty is a risk factor for teen pregnancy and school failure. Teen pregnancy prevention efforts, therefore, must incorporate strategies to give youth hope for the future and skills to meet the demands of a 21st century workforce. Data is drawn from the U.S. Bureau of the Census and other survey and program data. This information is shared with community partners through program reports and the publication of our annual Title V application and a Family Health in Rhode Island summary family health plan. Data are also reported through our partnership with Rhode Island Kids Count, which publishes an annual Factbook on child wellbeing. Data are used to identify trends in subpopulations and are reported in the context of contributing factors that impact the numbers and rates. The data are monitored over time to measure the effectiveness of interventions and to determine progress towards meeting goals.

In addition, the WIC Program uses poverty-level data in preparation of the WIC state plan, including ranking the relative need of communities. The program also uses this data to assess the effectiveness of outreach activities.

Early childhood programs use this data to determine estimated need for capacity of programs that serve families with demographic risk factors and to determine areas of targeted outreach.

Both programs designed to make out of home child care environments healthier and safer and programs targeted toward providing home visits to families with newborns use this data to focus efforts on areas of highest need.

The Adolescent Health Program uses this data to develop recommendations for adolescent systems and services, targeting resources to highest needs. The data will help policy makers determine existing services, the degree to which they meet population needs and what additional services are needed to provide comprehensive prevention efforts.

F. Other Program Activities

DCFHE initiatives and activities that were not fully discussed within the context of the National and State Performance Measures are described below.

Toll-Free Department of Health Information Line

The DCFHE supports a statewide toll-free telephone resource for all families in Rhode Island, called the Department of Health Information Line. Bi-lingual information specialists answer families' questions in English, Spanish and Portuguese about DCFHE programs, as well as a wide variety of health topics. Staff refers callers to appropriate community resources. Callers to the Department of Health Information Line include consumers, health care providers, school personnel, and community-based agencies. Culturally and linguistically appropriate informational materials are disseminated through the DCFHE's centralized distribution center.

The Department of Health Information Line received a total of 12,066 calls during the period 6/1/07-6/30/08. 58% were transferred to other programs within the Department of Health. 11.5% of the calls were related to WIC; 15.7% to immunizations; 3.74% to lead poisoning; 1.3% to mold and mildew; 0.0% to bio-terrorism; 0.36% to family planning; 0.04% to adolescent health; 0.12% to PRAMS; 0.56% to disabilities; 3.32% to KIDSNET; 0.09% to West Nile Virus; and 0.5% to child care. 84.8% of the callers were consumers, 11.3 % were health care providers, .9 were child care providers, .8% were social service providers, 1.5% were school personnel, .4% were WIC vendors, and 0.02% were legislators. //2010//

93.9% of the callers were English-speaking, 5.9% were Spanish-speaking, and 0.2% were Portuguese-speaking.

33.4% heard of the hotline via printed materials, 16.8% from the telephone book / information, 13.2% through the newspaper and 8.9% through another state agency.

KIDSNET & the Rhode Island Health Information Exchange

Rhode Island's Health Information Exchange (HIE) continues to develop a system for providing secure access to patient health information from a variety of local public and private information systems to authorized users. Currentcare, the state's HIE, will initially exchange laboratory and medication history data. Two years ago the state passed the HIE exchange act of 2008 which requires that patients are given the choice to participate (opt in). Enrollment has been occurring over the past 1.5 years and to date 60,000 patients have enrolled in the Currentcare. Currentcare will 1)allow a provider to access various sources of health data so that it can be viewed in an integrated and uniform manner, 2) eventually allow data from various sources to flow bidirectionally between EMRS and the HIE, 3)allow consumer control over who can access their data (in place), provide decision support to providers (e.g. immunization algorithm), and create the ability to utilize the data for public health purposes, including evaluation, surveillance, and research.

KIDSNET is actively participating in this project as a Data Sharing Partner. Through the KIDSNET communications channels, pediatric providers are informed about the HIE project. The KIDSNET database already aggregates data on a number of childhood preventive services for all children born after January 1, 1997. KIDSNET will also participate in the group's data standards committee to facilitate the use of data standards in RI's healthcare transactions.

Development of Rhode Island's Health Information Exchange (HIE) known as currentcare continues. Currentcare will provide an electronic system for providing secure access to patient health information from a variety of local public and private information systems to authorized users and will have the ability to interface with electronic medical records. Importantly participation in currentcare is voluntary; consumers must choose to enroll and can also choose who can access their data. KIDSNET is actively participating in this project and will become a Data Sharing Partner in the future. KIDSNET participates in the relevant committees and provides

expertise as needed related to data standards, matching, merging etc.

G. Technical Assistance

1. Adolescent Medical Home

The Perinatal and Early Childhood Health Team's Adolescent Health programs request technical assistance to develop and improve adolescent medical homes in Rhode Island. Professional development on resources such as Bright Futures, and other AAP provider tools is necessary to build local capacity to support medical homes. This request addresses NPM #3, NPM#8, NPM#13, SPM # 7, SPM #9, SPM #10.

2. We Can Energize Our Families Childhood Obesity Prevention

The Initiative for a Healthy Weight (IHW) is requesting technical assistance to support local partners with implementing the NHLBI's evidence-based We Can Energize Our Families childhood obesity prevention program. The program is a community-wide awareness campaign coupled with nutrition education, opportunities for physical activity, and social support. The program is designed to build community partnerships around obesity prevention while also providing parents and children with skills needed to make healthier choices. IHW would like to provide training from national We Can program experts to partners on the implementation, promotion, and evaluation of the program. This request addresses: NPM #5, 14 and SPM #2

V. Budget Narrative

Budget and expenditure data from Forms 3, 4, and 5 are provided for the application year, interim year, and reporting year to assist the reviewer in analysis of the budget and expenditure narrative. For complete financial data, refer to all the financial data reported on Forms 2-5, especially when reviewing the federal allocation on Form 2 for the 30%/30%/10% breakdown for the budgets planned for primary and preventive care for children, children with special health care needs, and administrative costs.

Form 3, State MCH Funding Profile

	FY 2009		FY 2010		FY 2011	
	Budgeted	**Expended**	**Budgeted**	**Expended**	**Budgeted**	**Expended**
1. Federal Allocation *(Line1, Form 2)*	1860000	553626	1860000		1770159	
2. Unobligated Balance *(Line2, Form 2)*	471103	688571	614421		1093295	
3. State Funds *(Line3, Form 2)*	1784133	1921961	2291092		2274575	
4. Local MCH Funds *(Line4, Form 2)*	0	0	0		0	
5. Other Funds *(Line5, Form 2)*	4985383	4784194	4461199		2191258	
6. Program Income *(Line6, Form 2)*	16896062	12909449	16926370		16862654	
7. Subtotal	25996681	20857801	26153082		24191941	
8. Other Federal Funds *(Line10, Form 2)*	48221512	59000367	53953316		41451278	
9. Total *(Line11, Form 2)*	74218193	79858168	80106398		65643219	

Form 4, Budget Details By Types of Individuals Served (I) and Sources of Other Federal Funds

	FY 2009		FY 2010		FY 2011	
I. Federal-State MCH Block Grant Partnership	**Budgeted**	**Expended**	**Budgeted**	**Expended**	**Budgeted**	**Expended**
a. Pregnant Women	1148892	591739	600836		800566	
b. Infants < 1 year old	2302639	2373238	2997195		2856696	
c. Children 1 to 22 years old	13065815	9626542	1867664		12224472	
d. Children with	3120267	1938435	2528664		2517480	

Special Healthcare Needs						
e. Others	5915968	5963237	17834418		5483282	
f. Administration	443100	364610	324305		309445	
g. SUBTOTAL	25996681	20857801	26153082		24191941	
II. Other Federal Funds (under the control of the person responsible for administration of the Title V program).						
a. SPRANS	0		0		0	
b. SSDI	110926		191949		238767	
c. CISS	151509		151291		145405	
d. Abstinence Education	0		0		0	
e. Healthy Start	52687		61324		70861	
f. EMSC	0		0		0	
g. WIC	24021092		25741608		6622726	
h. AIDS	7575030		7978287		9314759	
i. CDC	13025190		14947290		17523004	
j. Education	187232		56145		56145	
k. Other						
EPA	293337		524978		495370	
Federal Medicaid	0		0		1779693	
HRSA	675416		2083617		3127306	
Other (OSHA,NESHAP)	0		0		2077242	
Federal Medicaid	0		890620		0	
Other (OSHA, NESHAP)	562637		1326207		0	
federal medicaid	1566456		0		0	

Form 5, State Title V Program Budget and Expenditures by Types of Services (II)

	FY 2009		FY 2010		FY 2011	
	Budgeted	**Expended**	**Budgeted**	**Expended**	**Budgeted**	**Expended**
I. Direct Health Care Services	1173502	1748203	1996609		539835	
II. Enabling Services	1690156	518288	613445		639877	
III. Population-Based Services	14265753	13954892	17690182		17538872	
IV. Infrastructure Building Services	8867270	4636418	5852846		5473357	
V. Federal-State Title V Block Grant Partnership Total	25996681	20857801	26153082		24191941	

A. Expenditures

/2011/

Federal Grant Monitoring Procedures

The Division of Community Family Health and Equity (DCFHE) maintains budget documentation for block grant funding/expenditures for reporting consistent with Section 505(a) and section

506(a)(1) for auditing. All federal grants are monitored both within the Division and by HEALTH's Office of Management Services (OMS). The DCFHE Chief Programs Operations meets with DCFHE team and program staff to review spending, performance, and quality assurance issues for each federal grant. The OMS reviews each federal grant monthly for cost and data reporting issues. Any non-compliance, such as delays in progress reports or personnel hiring or lack of billing, requires an immediate response by the DCFHE Chief Programs Operations. Federal financial status reports (FSRs) are due within three months of the close of a federal grant. HEALTH consistently submits FSRs correctly and on-time.

HEALTH Policies for Contracting & Purchasing

Any purchase made with federal or state dollars requires prior approval. In addition, all purchases must be approved by the DCFHE Chief Programs Operations. Once approved, the request to purchase form must be signed by OMS staff and then approved by the state Office of Purchasing. There are detailed policies for allowable and non-allowable purchases. These policies include restrictions on types of purchases, like gifts and food, as well as travel guidelines. There are procedures in place for the State of Rhode Island to assure that competition exists between all providers for federal and sate dollars. State departments are allowed to make some purchases without the approval of the Office of Purchasing under certain detailed guidelines.

There are detailed procedures for establishing and monitoring contracts and grants at HEALTH. HEALTH staff cannot enter into a contract with a provider without following certain steps. There are two mechanisms for awarding funds at HEALTH: 1) through a competitive request for proposals (RFP) process and 2) through a grant based on need, legislative requirements, or through a formula funding mechanism. There are detailed requirements for RFPs including appropriate language in the proposals, submission of offers, appeals, public review, and use of minority businesses. An RFP template must be followed for all RFPs and the document is reviewed by the DCFHE and the OMS before dissemination. The RFP process also requires a formal review of procedures used to select vendors, including an independent session with Office of Purchasing staff. A grant may be awarded to a Rhode Island-based non-profit agency for an identified need, if the agency is solely capable of addressing the need or if there is a legislative requirement to award funds to a particular agency or if HEALTH is awarding funds to all capable agencies through a funding formula. Once approval is received to enter into a grant, DFCFHE staff must then follow procedures for establishing contracts.

Procedures for contract management includes the establishment and modification of contracts, which is the responsibility of the OMS, while the monitoring of contract compliance is a DCFHE responsibility. The DCFHE's Key Administrator meets with DCFHE Team Leads and Contract Management staff to review contract compliance and other administrative issues. Contract monitoring includes approval and signatures for appropriate charges to each contract and contract performance and progress. The DCFHE has the ability to hold back payments or terminate contracts for issues related performance and progress. DCFHE program managers must review the appropriateness of all charges against a contract. Any variation in billing from the established contract must be requested in writing before reimbursements are made. DFH program managers are also responsible for the day-to-day oversights of contracts, monitoring performance, quality assurance, and billing procedures. The program managers regularly conduct performance reviews and customer satisfaction surveys for programs receiving state and federal funds.

Audits & Controls

Audits from both the state Office of the Auditor General and the state Bureau of Audits are conducted at HEALTH annually. The DCFHE has frequently been audited - the WIC Program is audited annually and the Immunization Program and Family Planning were both audited in the recent past. HEALTH's OMS conducts audits of DCFHE contracts regularly and monitors payments. In addition to external audits, the DCFHE routinely audits all of its sub-contracted

agencies and requires formal audits to be sent to the DCFHE annually.

HEALTH's division managers must submit an annual financial audit review to monitor controls on contracts, personnel, budget, and other administrative policies. These financial audits are reviewed by the state's Financial Officer for compliance with existing state policies.

2009 Expenditures

See the FY09 Expended columns in Form 3 (State MCH Funding Profile), Form 4 (Budget Details by Type of Individuals Served), and Form 5 (State Title V Programs Budget and Expenditures by Type of Services). The Form and Field Notes for the Forms provide additional details and explanations about the amounts shown, including differences between budgeted and expended amounts shown, changes in the level of funding across years, and the sources of State Partnership funds and other Federal funds.

Form 3 (State MCH Funding Profile)
The final unobligated expended for FY09 is more than the original budget estimate by more than 10%. The reason for this apparent discrepancy is that the original unobligated estimate was too low due to the need to spend carry-over (unobligated funds) first before spending the federal FY09 allocation. An increase in the expended unobligated balance created a decrease in the amount of federal allocation expended. The total amount of FY09 unobligated balance and federal allocation is less than budgeted due to delays in project spending and offsetting MCH projects to other federal grants. The program income expended is less than budgeted due to less childhood and adult immunization spending with restricted funds.

Form 4 (Budget Details by Type of Individuals Served) and Form 5 (State Title V Programs Budget and Expenditures by Type of Services)
Rhode Island has continued to be successful for FY 09 expended funds in meeting the budget requirements of at least 30% of our federal MCH funds was utilized for Preventive and Primary Care for Children (30%) and at least 30% for Children with Special Health Care Needs (41%). The proportion of federal MCH funds expended for FY09 is 9.5%, which is under the allowable 10%.

Both forms represent an overall decrease in state partnership spending and variances for distributions of funding among the MCH populations and services types due to a couple of reasons. The state funding included in the State Partnership was subject to state budget reductions. Secondly, the FY09 expended reflects variances among with disbursement of funds for MCH populations compared to the FY09 budgeted. For Pregnant Women, Children 1 to 22 years of age and Children with Special Health Care Needs, the HIV treatment, smoking cessation and tobacco prevention all reflect shifts in the disbursement of funds for these populations. As for type of services, the reason for the variance in type direct service is that for the FY09 budget, the HIV treatment program was reflected to be a portion provided under direct service for type of service and for the FY09 expended, HIV is 100% direct service. The shift in HIV expenditures also impacts the variance for enabling services and infrastructure services. In addition to the variance in HIV, the childhood and adult immunization budget funding also impacted the variance for infrastructure building services for FY09 expended. A portion of immunizations expenditures were not included in the FY09 budget as infrastructure services, but is in the FY09 expended. While there is an apparent variance in infrastructure, it is not as apparent for population based services. While the HIV expenditures varied from the FY09 budget, the shift is obvious since the immunization FY09 budget funds shifted to population based services in FY 09 expended.
//2011//

B. Budget

/2011/ Budget Narrative
In FY2011, the Division proposes to spend $1,770,159 including a estimated carry forward of $1,093,295 from FY2010. Our Office of Children with Special Health Care Needs will continue to expand and address the needs of vulnerable young children and adolescent, investing in parent involvement and system building during FY11. Community, Family Health and Equity (CFHE) continues to focus on the rising birth rate, children's mental health, adolescent health/teen pregnancy prevention, and early childhood investments. CFHE 2011 budget allocates $1,770,159, of which 36.5% ($646,975) will be expended on children with special care needs, 33.3% ($589,943) will be expended on preventive services for children and 5.91% ($104,561) was allocated for administrative cost. The Division's budget for FY2011 presents a decrease in funding with a budget of $65,643,219 (not including $1,773,489 of state Medicaid match funds) due to only one quarter of the WIC program funding included in the FY11 enacted budget since the program is expected to transfer to Office of Health & Human Services beginning Oct 1, 2010. In addition to the transfer WIC, CFHE has received seven new federal ARRA grants to be included in FY11 and also the addition of CNOM HIV and Women's Cancer Screening funding.

Our Maternal and Child Health investment for FY2009 was $79,858,168 including $6,706,155 of state and restricted newborn screening funding, excluding program income and private funds.

The maintenance of effort amount for FY2009 and for proposed FY2011 exceeds the FY89 level of effort of $1,875,000. Our commitment to Kids Net, Parent Consultants, Newborn Screening, and Adolescent Health are some of the ways that RI commits state funds to maintain its match with HRSA, Title V. Rhode Island defines administrative costs as those costs associated with disbursing funds from a central office (e.g., budgeting, oversight) that fall within the purview of administration. This is consistent with a legal opinion on the subject obtained by the Association of Maternal and Child Health Programs.

Rhode Island proposes to expend approximately $5,473,357 of the total state resources from all sources (including program income and private funds) on core public health/infrastructure activities. RI proposed to expend $17,538,872 on population based services which is consistent to the amount proposed for FY10. The proposed amount of $539,835 for direct health care services is a 73% decrease from the previous year (FY10: $1,996,609) due to a reduction in the overall budget from FY10 of $26,153,082 to FY11 of $24,191,941 while continuing to maintain consistency in the types of services categories for FY11 compared to FY10.

The Division's Executive Office guides the process of assuring that funded MCH grant projects are aligned with the MCH priorities. The Division's Title V Maternal and Child Health Block Grant uses a life course development approach in addressing the social determinants of health as a framework for health planning.

The Division plans to allocate its FY2011 award to meet the goals outlined in the annual plan by purchasing services from and contracting with other state agencies and community-based providers using standard purchasing procedures including RFPs, and sole/single source provider justifications. Every contract is managed by a Team Lead or program manager, as well as monitored by fiscal staff. Payment for services outlined in the contract is reviewed and approved by the contract officer and the division Chief Program Operations prior to reimbursement. //2011//

VI. Reporting Forms-General Information
Please refer to Forms 2-21, completed by the state as part of its online application.

VII. Performance and Outcome Measure Detail Sheets
For the National Performance Measures, detail sheets are provided as a part of the Guidance. States create one detail sheet for each state performance measure; to view these detail sheets please refer to Form 16 in the Forms section of the online application.

For the detail sheets and objectives for the state performance measures developed from the 2010 needs assessment, refer to TVIS Forms, Form 11 and Form 16 under the section “New State Performance Measure Detail Sheets and Data.

VIII. Glossary
A standard glossary is provided as a part of the Guidance; if the state has also provided a state-specific glossary, it will appear as an attachment to this section.

IX. Technical Note
Please refer to Section IX of the Guidance.

X. Appendices and State Supporting documents
A. Needs Assessment
Please refer to Section II attachments, if provided.

B. All Reporting Forms
Please refer to Forms 2-21 completed as part of the online application.

C. Organizational Charts and All Other State Supporting Documents
Please refer to Section III, C "Organizational Structure".

D. Annual Report Data
This requirement is fulfilled by the completion of the online narrative and forms; please refer to those sections.